DOCUMENT RESUME

ED 050 281 VT 013 093

TITLE	Comprehensive Statewide Planning for Vocational Rehabilitation Services, Connecticut. Final Report, (Appendix), Volume II.
INSTITUTION	Connecticut State Dept. of Education, Hartford. Div. of Vocational Rehabilitation.
SPONS AGENCY	Rehabilitation Services Administration (DHEW), Washington, D.C.
PUB DATE	10 Oct 68
NOTE	418p.
EDRS PRICE	EDRS Price MF-$0.65 HC-$16.45
DESCRIPTORS	Administrative Agencies, Community Attitudes, Community Organizations, Counseling Services, Educational Needs, *Handicapped, *Interagency Coordination, Job Market, Legislation, Manpower Needs, *Program Improvement, Reports, *State Programs, *Vocational Rehabilitation

ABSTRACT

This document contains the supplementary and supportive material on which the final report (Volume I) is based. Statistical reports of staff studies, summaries of testimony presented at public hearings, profiles and reports of regional committees, reports of technical committees, and reports of radio, television and newspaper coverage are presented. Related documents are available as VT 013 092 and VT 013 094-013 096. (GEB)

ED050281

Final Report Appendix

Comprehensive Statewide Planning
for
Vocational Rehabilitation Services

QUI
TRANSTULIT
SUSTINET

CONNECTICUT

Volume II

VT013093

ED050281

U.S. DEPARTMENT OF HEALTH, EDUCATION
& WELFARE
OFFICE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY

VOLUME II

FINAL REPORT

(APPENDIX)

COMPREHENSIVE STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION SERVICES

CONNECTICUT

THE UNIVERSITY OF CONNECTICUT
1881

DIVISION OF VOCATIONAL REHABILITATION
STATE DEPARTMENT OF EDUCATION
600 Asylum Avenue
HARTFORD, CONNECTICUT

WESLEY C. WESTMAN, PhD.
PROJECT DIRECTOR

INCLUSIVE PERIOD OF PLANNING PROJECT
October 10, 1966 - October 10, 1968

This planning program was supported by a grant, under Section 4(a)(2)(b), from the Rehabilitation Services Administration, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D.C.

This volume contains the supplementary and supportive material on which the final report, contained in Volume I, is based.

DISCRIMINATION PROHIBITED - Title VI of the Civil Rights Act of 1964 states; "No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Therefore, all programs and activities receiving financial assistance from the Department of Health, Education, and Welfare must be operated in compliance with this law.

1/2/3/4.

CONNECTICUT STATE BOARD OF EDUCATION

William Horowitz, Chairman	New Haven
Mrs. Virginia D. Christian	Norwich
Charles W. Phelps	Andover
G. Eugene Goundrey	Middletown
Mrs. Jane D. Humphries	Norfolk
Donald M. Johnson	West Hartford
Margaret Kiely	Bridgeport
Mrs. Minnie G. MacDonald	Putnam
George D. Pratt, Jr.	Bridgewater

William J. Sanders, PhD.
Secretary and Commissioner of Education

William H. Flaharty, PhD.
Assistant Secretary and Deputy Commissioner

James S. Peters,11, PhD.
Director, Division of Vocational Rehabilitation

STATE PLANNING COUNCIL FOR VOCATIONAL REHABILITATION SERVICES

Chairman
Joseph Ress
Attorney at Law

John C. Allen, M.D., Physiatrist
Department of Physical Medicine
Hartford hospital

Herbert A. Anderson
Connecticut Hospital Association

David Boynick
Assistant to the Commissioner
Mental Health Department

William H. Cowell, Pharmacist
Stamford Hospital

Arthur DuBrow, Director
Community Services
Office of Mental Retardation
Department of Mental Health

Joseph P. Dyer, Director
Bureau of Program Management &
Supporting Services
Department of Community Affairs

Mrs. Glenn Farmer
Former State Legislator

Cyrus G. Flanders, Executive Secreta
Governor's Committee on Employment
of the Handicapped
State Labor Department

Harold Hegstrom, Special Assistant
Department of Corrections

Carmine Lavieri
Attorney at Law

Miss Lorraine Loiacono, Chief
Medical Social Work Services
Department of Welfare

H. Kenneth McCollam, Director
Board of Education & Service
for the Blind

Miss Gertrude Norcross, Executive Director
Connecticut Society for Crippled
Children and Adults

Carmen Romano, Director
Dwight Project
New Haven Redevelopment Agency

George Sanborn, Ph. D. Chief
Office of Departmental Planning
Department of Education

Miss Ann Switzer, Excutive Director
Connecticut Association for
Retarded Children, Inc.

George Walker, M.D. Coordinator
Comprehensive Health Planning
Department of Health

Thomas Yoczik, Chief
Apprentice Training Division
Labor Department

PROJECT STAFF

Project Director	Wesley C. Westman, Ph. D.
Assistant Director & Research Planning Associate	Frank C. Grella
Publications Associate	Helen D. Hathaway
Research Analyst	Donna L. Friedeberg
Project Secretary	Rita Langevin
Research Consultants	Aubrey Escoffery, Ph. D. Professor of Psychology Virginia State College Cecelia Welna, Ph. D. Chairman, Mathematics Department University of Hartford Stanley Young, Ph. D. School of Business Administration University of Massachusetts Stephen F. Thoma, Ph. D.
Research Assistants	Kevin Baack Evelyn Lewis
Publicity	Helen Loy
Editorial Assistant	Dorothy Hoagland
Typists	Marlene Neubauer Germaine Bolduc Sharon Reid Mary Ann Reliford

TABLE OF CONTENTS

CHAPTER I - STAFF STUDIES AND REPORTS

STATISTICAL REPORTS

Characteristics of Active Case Load ---------------------------- 10
Characteristics of Rehabilitation Clients ---------------------- 11
Work Status and Referral Sources of Clients -------------------- 16
Estimates of Disabled Eligible (1967) -------------------------- 18
Cost-Benefit Analysis in Rehabilitation ------------------------ 20
Findings of Questionnaire -------------------------------------- 24
Classifications of Disabling Conditions and Causes ------------- 28
Vocational Rehabilitation System ------------------------------- 37
Choosing Objectives by Benefit Analysis ------------------------ 95

CHAPTER II - SUMMARY OF TESTIMONY PRESENTED AT PUBLIC HEARING

Moderator - Joseph E. Ress --------------------------------------124

Welcoming Address - The Honorable John N. Dempsey
Governor of Connecticut ------------------- 124

Keynote Address - The Honorable Ella T. Grasso
Secretary of State, Connecticut ------------- 128

Introductory Speaker - William J. Sanders, Ph.D.
Commissioner of Education -------------- 134

Increased DVR Services in Correction - J. Bernard Gates,
Executive Director, Connecticut Prison Association ---------- 135

Needs of the Cerebral Palsied - Maurice Myrun, President
Cerebral Palsy Association of Greater Hartford -------------- 138

Three Major Areas of Need - Jack Sage, Planning Associate
Community Council of Greater New Haven ---------------------- 141

Rehabilitation and the Elderly - Sholom Bloom, Executive
Secretary, Commission on Services for Elderly Persons ------- 142

Barriers - Arnold Lawrence, A.I.A. Architect ------------------ 144

Problems of Employment Among Minorities - Sam Wilson, Director
Economic Development and Employment, Urban League ----------- 145

Needs of the Blind - Ralph Adams, President
Alumnae Association, Oak Hill School ------------------------ 147

Importance of Vocational Training to the Handicapped -
Bob Foss, Executive Director Emeritus, Newington Home
For Crippled Children --------------------------------------149

Effects of Austerity Program in Connecticut - Alan A. Dun, M.D.
President, Connecticut Rehabilitation Association -----------151

TABLE OF CONTENTS

New Horizons - Monroe Fearing, Secretary, Board of Directors, New Horizons, Inc. -------------------------- 153

Connecticut's Retarded Children - Elisabeth M. Stabler, Executive Director, Aid for Retarded Children, Inc. ---- 155

The "Hardcore" Disadvantaged - Robert Davis Hartford Human Relations Department -------------------- 158

Special Education Needs - Robert LaCamera, M.D. Medical Director, Children's Services of New Haven ------------- 161

Hiring the Handicapped - Alice P. Irwin, Treasurer and Production Manager, Hartford Element Company ----------- 163

DVR and the Sheltered Workshop - Carl V. Puleo, Executive Director, Goodwill Industries, Central Connecticut ----- 166

Muscular Dystrophy - Joseph Burns, Muscular Dystrophy Association -- 168

Education and Learning Disabilities - Beatrice R. Fleeson, Executive Director, Greater Hartford Association for Retarded Children -------------------------------------- 171

DVR and the Legislature - Arline Ryan, Representative Connecticut Legislature -------------------------------- 173

Rehabilitating the Alcoholic - James E. Carroll, Rehabilitation Counselor, Alcoholism and Drug Dependency Unit, Connecticut Valley Hospital --------------------------- 175

Rehabilitating the Emotionally Disturbed - Robert E. Bacon, Member, President's Committee on Employment of the Handicapped --- 182

Handicapped in Industry - Arthur Arsenault, Vice President Uniform Services, Waterbury --------------------------- 187

Needs of Mentally Ill - Robert T. Morrison, A.C.S.W. Chief, Psychiatric Social Service, Norwich Hospital ---- 188

Economic Values of Rehabilitation - Charles Alfano, Senator Connecticut Legislature ------------------------------- 191

Out-Patient Rehabilitation Services - F. Thomas Ulrich, R.P.T. Director, Easter Seal Center, Southwestern Connecticut --193

The Cardiovascular Patient - Nicholas J. Lavnikevich Heart Association of Norwich -------------------------- 194

Developing the Handicapped's Potential - Fred F. Finn Superintendent, Seaside Regional Center -----------------196

TABLE OF CONTENTS

Cooperation Among Agencies - Thomas B. Ritchie* Former Capitol Regional Mental Health Planner ------------- 201

The Potentially Employable - Robert W. Butler, M.D. Medical Director, Scovil Manufacturing Company ------------ 203

Architectural Barriers - Lillian Frankl, Chairman, Speakers Committee, Board of Directors, Rehabilitation Center, Southern Fairfield County ---------------------------------- 205

The Veteran and Rehabilitation - Francis E. Miner, Assistant Commandant, Veterans' Home and Hospital ------------------ 207

Problems of the Multiple-handicapped - Karen Kagey, Director Society to Advance the Retarded ------------------------- 208

Planning For Services - Richard K. Conant, Jr. Health Education Project, Griffin Hospital ---------------- 211

CHAPTER III PROFILES AND REPORTS OF REGIONAL COMMITTEES

Bridgeport Profile -- 215
Final Report of Bridgeport Regional Committee --------------- 230

Hartford Regional Profile ---------------------------------- 237
Final Report of Hartford Regional Committee ----------------- 249

New Haven Regional Profile --------------------------------- 269
Final Report of New Haven Regional Committee ---------------- 283

Norwich Regional Profile ----------------------------------- 291
Final Report of Norwich Regional Committee ------------------ 303

Waterbury Regional Profile --------------------------------- 321
Final Report of Waterbury Regional Committee ---------------- 334

CHAPTER IV. REPORTS OF TECHNICAL COMMITTEES

Technical Advisory Committee on Inter-Agency Cooperation ---- 349

Technical Advisory Committee on Research -------------------- 393

Technical Advisory Committee on Legislation ----------------- 398

CHAPTER V. RADIO, TELEVISION AND NEWSPAPER COVERAGE

Radio Interview - Dr. Westman ------------------------------- 404
Television Interview: Mr. Grella, Miss Loiacono, Dr. Peters- 409
Representative News Coverage -------------------------------- 422

* Deceased

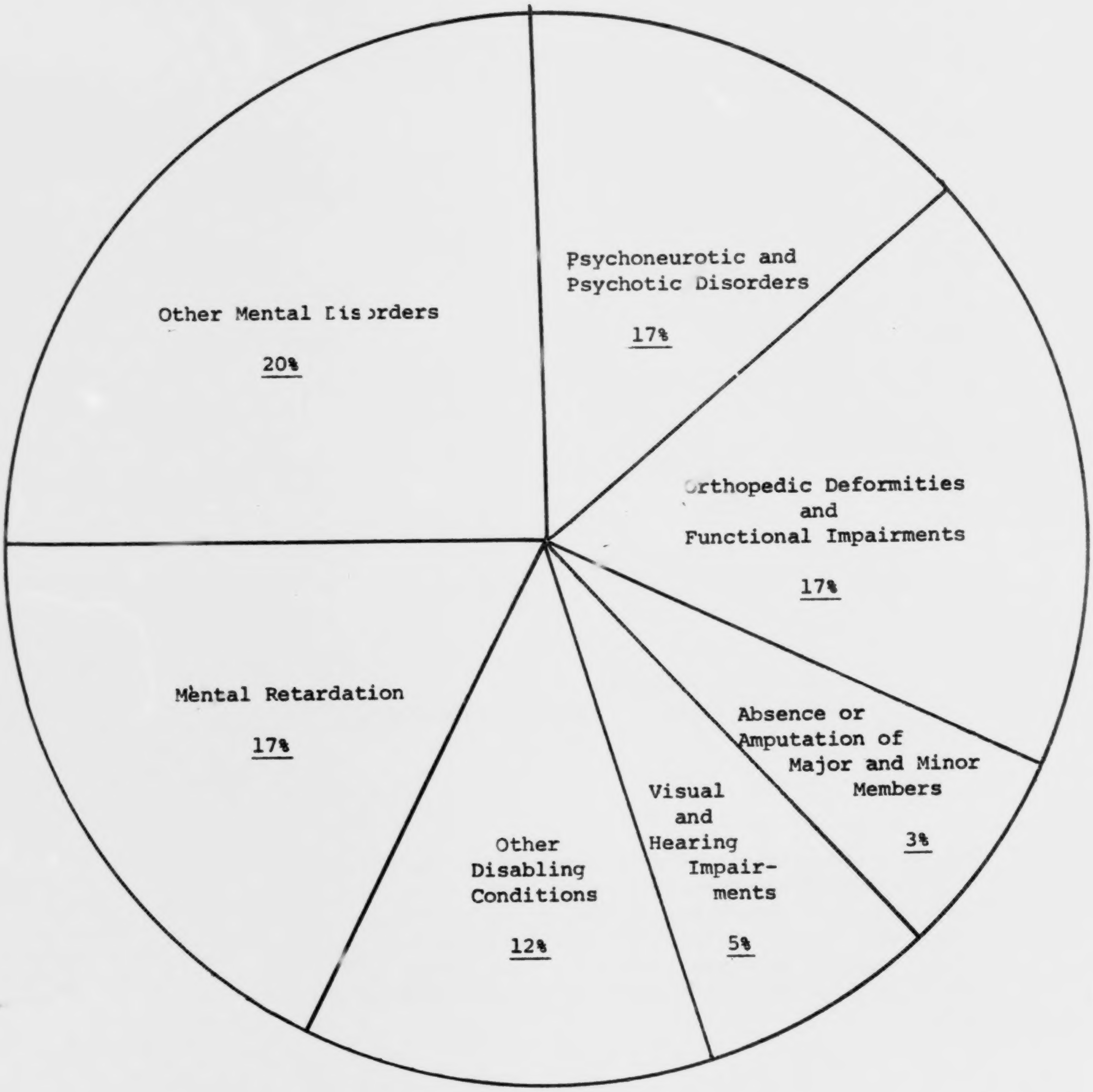
STATISTICAL REPORTS

Prepared by:
Frank C. Grella Donna L. Friedeberg

These Statistical reports were issued in the course of the project for information to members of the regional and technical committees as well as to the supervisory personnel of the Division of Vocational Rehabilitation. These reports represent part of a much larger body of data, particularly that relating to cost-benefit analysis.

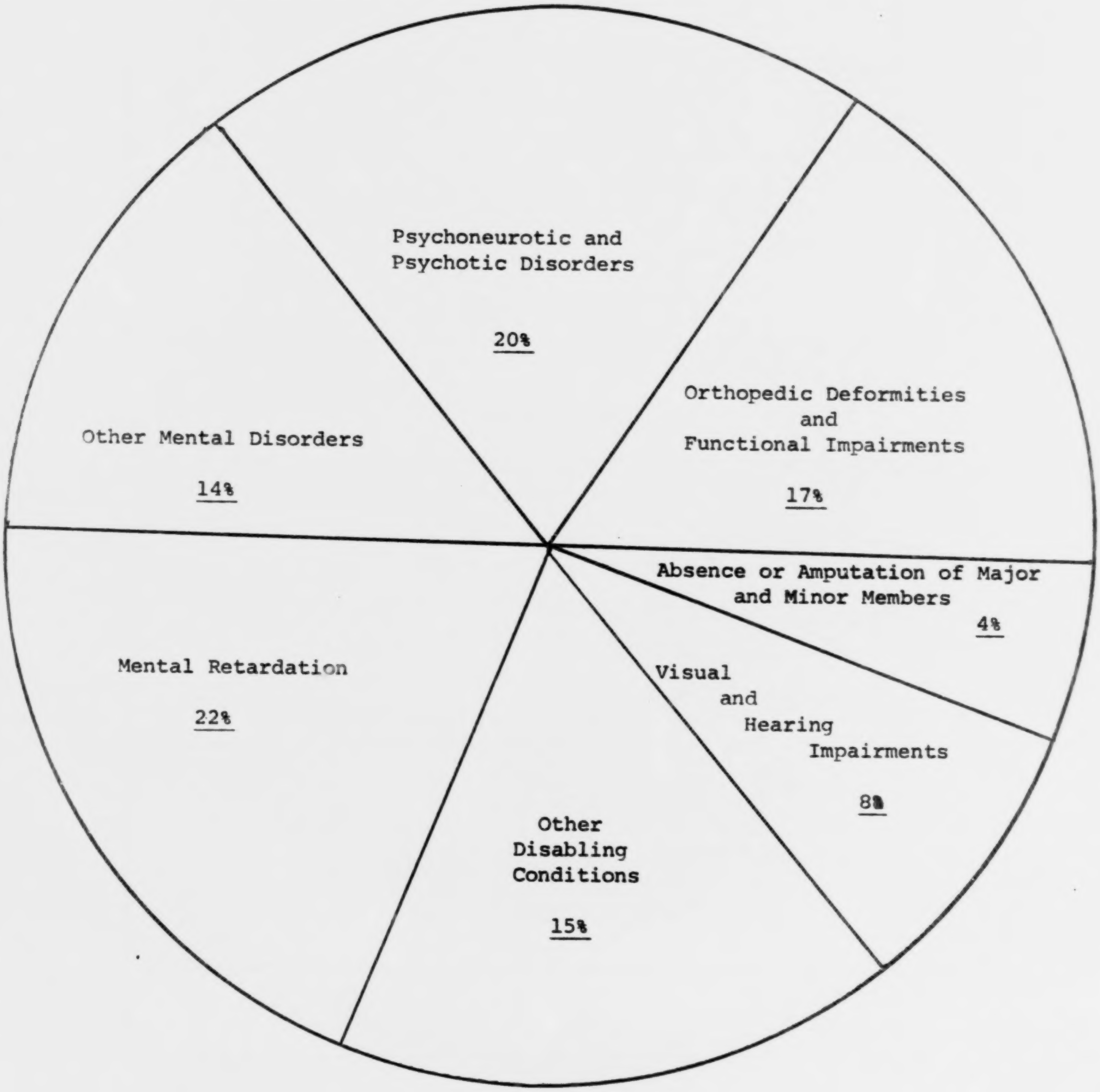
10.

ACTIVE CASE LOAD BY DISABILITY
November, 1967



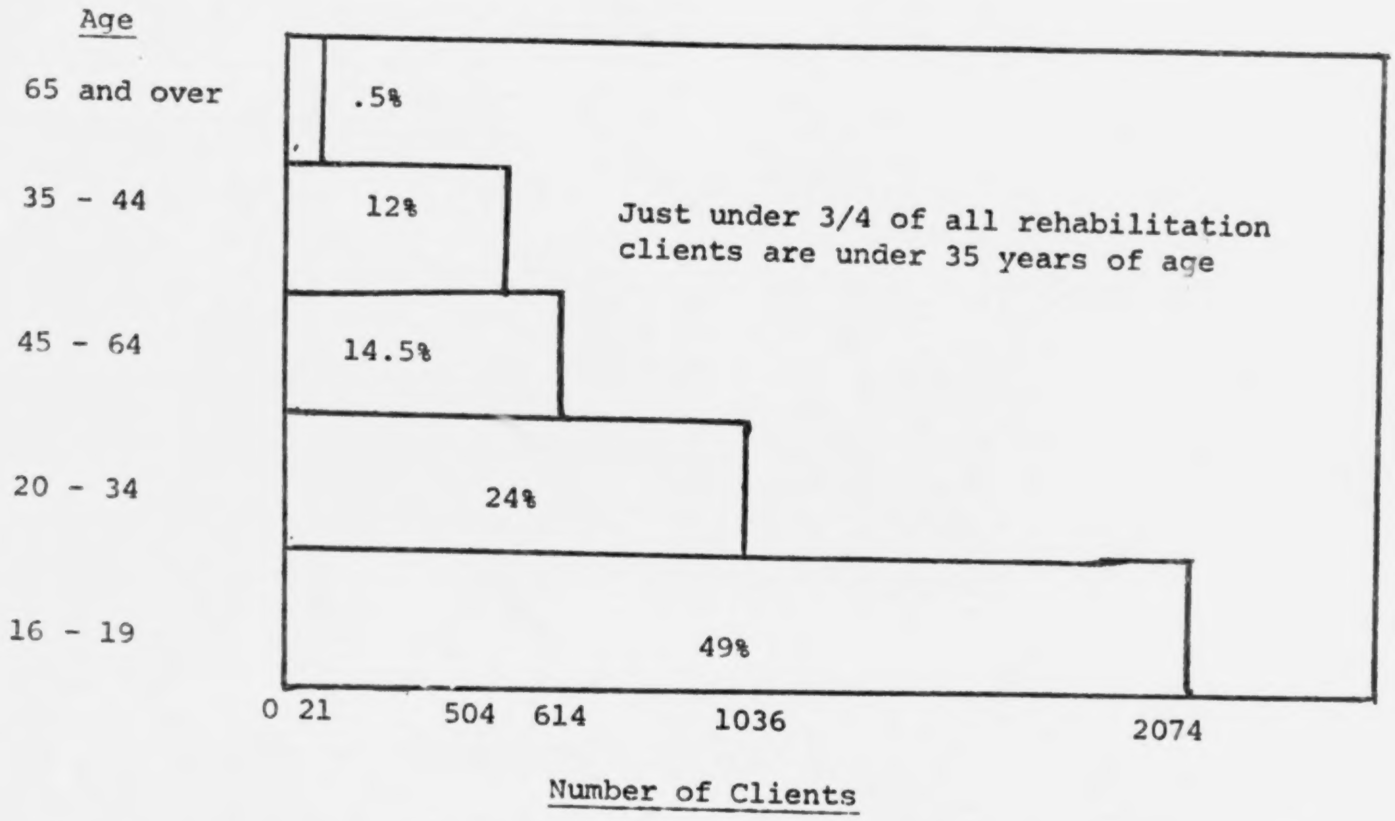
Source: Summary of 4249 clients on active case load, November 1967, State of Connecticut, Division of Vocational Rehabilitation.

REHABILITATED CLIENTS BY DISABILITY
July 1, 1966 - June 30, 1967



Source: Summary of 1547 rehabilitated clients, fiscal year 1966-67, State of Connecticut, Division of Vocational Rehabilitation.

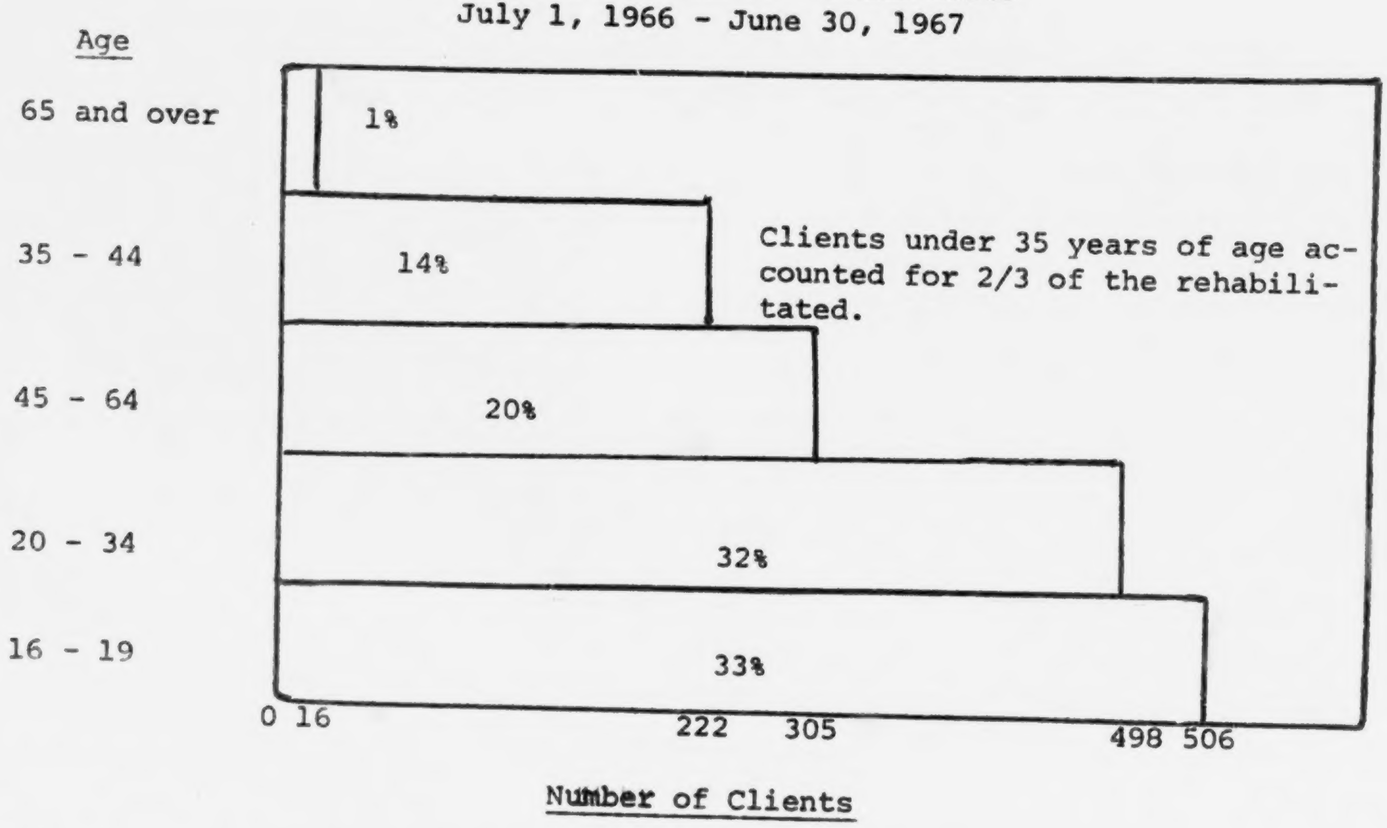
ACTIVE CASE LOAD BY AGE GROUP, NOVEMBER, 1967



Just under 3/4 of all rehabilitation clients are under 35 years of age

Source: Summary of 4249 clients on active case load, November 1967, State of Connecticut, Division of Vocational Rehabilitation

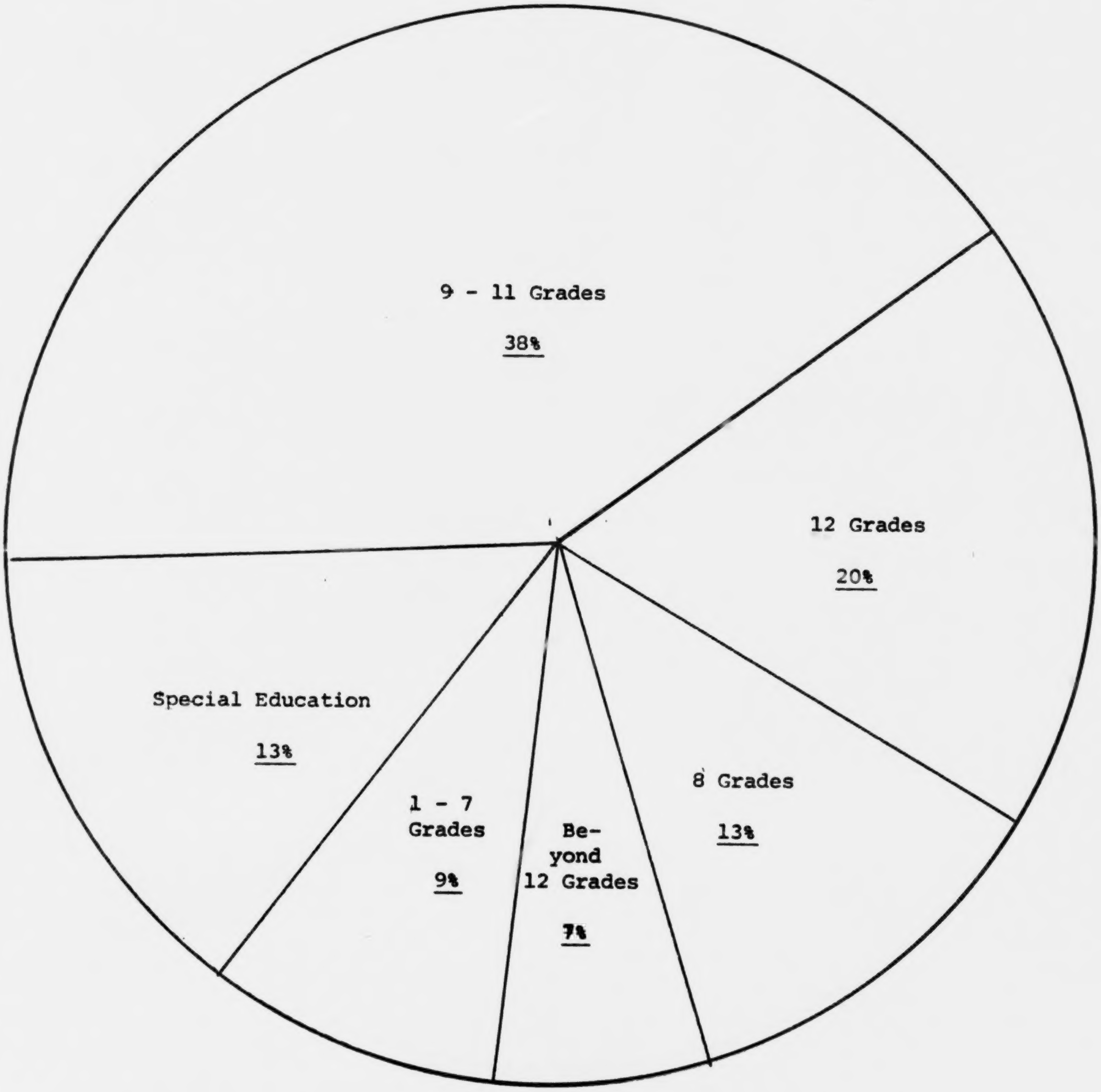
REHABILITATED CLIENTS BY AGE GROUP
July 1, 1966 - June 30, 1967



Clients under 35 years of age accounted for 2/3 of the rehabilitated.

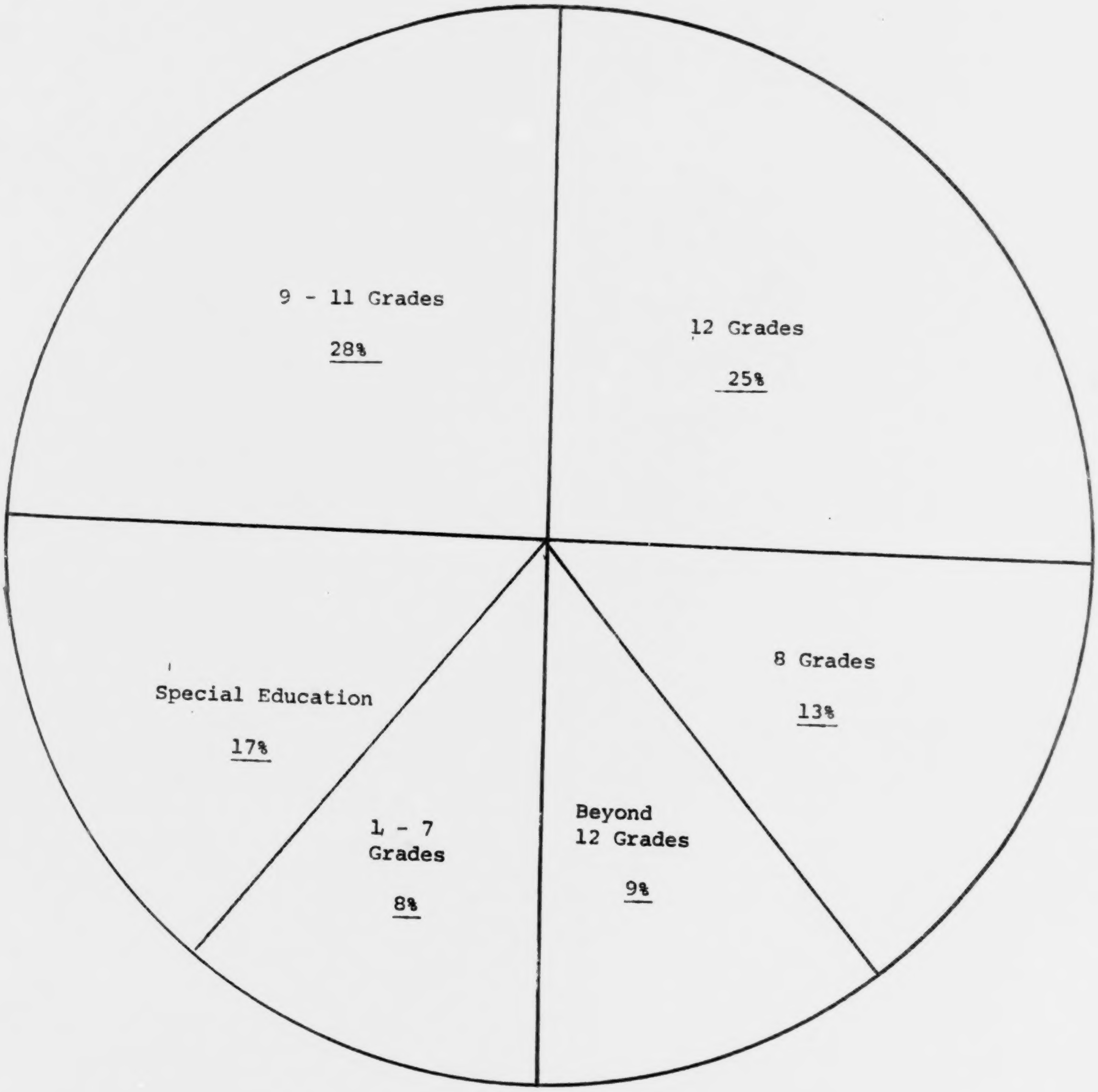
Source: Summary of 1547 rehabilitated clients, fiscal year 1966-67, State of Connecticut, Division of Vocational Rehabilitation.

ACTIVE CASE LOAD BY EDUCATION
November, 1967



Source: Summary of 4249 clients on active case load, November 1967, State of Connecticut, Division of Vocational Rehabilitation.

REHABILITATED CLIENTS BY EDUCATION
July 1, 1966 - June 30, 1967



Source: Summary of 1547 rehabilitated clients, fiscal year 1966-67, State of Connecticut, Division of Vocational Rehabilitation.

OTHER CHARACTERISTICS OF THE ACTIVE CASE LOAD

November, 1967

Sex

59% of the case load is male.

Race

78% of the case load is White.
22% of the case load is Negro.

Marital Status

69%	Never Married
20%	Married
9%	Divorced or Separated
2%	Widowed

Number of Dependents

80%	No Dependents
8%	2 or 3 Dependents
6%	4 or more Dependents
6%	1 Dependent

Source: Summary of 4249 clients on active case load, November 1967, State of Connecticut, Division of Vocational Rehabilitation.

OTHER CHARACTERISTICS OF REHABILITATED CLIENTS

July 1, 1966 - June 30, 1967

Sex

62% of rehabilitated clients is male.

Race

86% of rehabilitated clients is White.
14% of rehabilitated clients is Negro.

Marital Status

61%	Never Married
27%	Married
10%	Divorced or Separated
2%	Widowed

Number of Dependents

75%	No Dependents
10%	2 or 3 Dependents
8%	4 or more Dependents
7%	1 Dependent

Source: Summary of 1547 rehabilitated clients, fiscal year 1966-67, State of Connecticut, Division of Vocational Rehabilitation.

WORK STATUS OF CLIENTS REHABILITATED IN FISCAL YEAR 1966-1967
AT ACCEPTANCE AND AT CLOSURE BY DISABILITY

Disability Categories	Wage or Salary Competitive		Wage or Salary Sheltered		Self-employed except BEP		State Agency-Managed		Homemaker		Unpaid Family Worker		Non-working Student		Non-working Other	
	AA[1] Percent[2]	AC	AA Percent	AC	AA Percent	AC	AA Percent	AC	AA Percent	AC	AA Percent	AC	AA Percent	AC	AA Percent	AC
Visual Impairments	19	100	5	0	0	0	0	0	3	0	0	0	24	0	49	0
Hearing Impairments	42	88	0	1	1	2	1	0	7	7	0	0	10	0	38	0
Orthopedic Impairments-other	17	95	2	3	0	2	0	0	1	0	0	0	14	0	66	0
Orthopedic-1 or both lower limbs	14	87	1	2	0	2	0	0	4	7	[illegible]	1	14	0	62	0
Orthopedic-other and ill-defined	15	91	0	1	0	4	0	0	1	3	1	0	0	0	82	0
Absence or Amputation of limbs	24	88	0	2	5	1	0	0	8	9	0	0	5	0	58	0
Psychotic Disorders	5	93	0	4	0	1	0	0	0	1	0	0	4	0	90	0
Psychoneurotic Disorders	15	96	1	1	1	1	0	0	1	2	0	1	10	0	70	0
Other Mental Disorders	3	94	1	*	*	0	0	*	0	5	*	*	49	0	46	*
Mild Mental Retardation	4	92	4	6	0	0	0	0	0	1	1	1	49	0	41	0
Moderate Mental Retardation	4	84	6	13	0	0	1	0	1	1	1	2	26	0	60	0
Servere Mental Retardation	0	35	8	65	0	0	0	0	0	0	0	0	14	0	78	0
Cardiac and Circulatory Conditions	15	87	0	2	0	2	0	0	6	11	0	0	8	0	71	0
Respiratory Diseases	10	95	0	2	2	0	0	0	0	3	0	0	3	0	85	0
All Others	12	88	1	4	1	0	0	0	3	8	1	0	17	0	65	0

[1] AA = At Acceptance
AC = At Closure

[2] Percentages of the total clients in the categories at acceptance and at closure in each status

*Less than one per cent

REFERRAL SOURCES[1] OF CLIENTS REHABILITATED IN FISCAL YEAR 1966-1967 BY DISABILITY

Disability Categories		Educational Insts.	Hospitals & Sans.	Other Health Agens.	Physicians	Social Sec. Admn.	Workmen's Comp.	Welfare Agencies	State Emp. Servc.	Artificial Ap. Co.	Individual	Self-referred	Other Sources
	No.	%	%	%	%	%	%	%	%	%	%	%	%
Visual Impairments	37	19	5	5	0	0	0	11	27	0	5	22	6
Hearing Impairments	81	6	4	21	4	0	0	6	10	17	9	17	6
Orthopedic Impairments	256	7	12	12	9	5	0	10	18	1	8	13	5
Amputation or Absence of limbs	65	3	18	8	6	2	0	14	9	9	8	17	6
Psychotic Disorders	161	3	71	3	4	1	0	1	6	0	4	6	1
Psychoneurotic Disorders	147	5	34	6	18	2	0	6	14	0	5	7	3
Other Mental Disorders	219	45	22	3.5	2	1	0	6	3.5	0	5	3	9
Mild Mental Retardation	149	61	2	20	0	1	0	4	5	0	3	1	3
Moderate Mental Retardation	157	62	2	18	1	0	0	3	6	0	5	0	3
Severe Mental Retardation	37	40	0	46	0	0	0	3	3	0	5	3	0
Cancer	2	0	0	0	50	0	0	0	0	0	50	0	0
Allergies and Internal Disorders	16	12.5	12.5	0	0	6	6	6	19	0	13	19	6
Blood Disease	1	100	0	0	0	0	0	0	0	0	0	0	0
Nervous System Disorders	37	19	21.5	11	3	3	0	8	13.5	0	8	8	5
Cardiac and Circulatory Conditions	66	6	19.5	15	7.5	6	0	11	11	0	7.5	7.5	9
Respiratory Diseases	59	2	47	5	3	9	0	9	17	0	2	3	3
Digestive Disorders	20	0	40	0	0	0	0	10	35	0	5	5	5
Speech Impairments	24	17	13	8	4	0	0	4	21	0	8	4	21
Other Disabling Conditions	13	0	15	8	0	0	0	15	23	0	8	31	0

---

[1] Correctional Institutions referred no clients rehabilitated in fiscal year 1966-1967.

CLIENTS REHABILITATED, ACTIVE CASE LOAD, AND ESTIMATED ELIGIBLE IN 1967

Disability Categories	No. Rehabilitated Fiscal Year, 1967	No. in the Nov. 67 Active Case load	Estimated Eligible 1967	% of the Total Estimated Eligible
Blindness	170[1]	300	600	.6%
Other Visual Impairments	35	79	9200	8.7%
Hearing Impairments	81	125	3200	3.0%
Orthopedic - Paraplegia	16	108	4410*	4.2%
Orthopedic - Hemiplegia	39	89	3646*	3.4%
Orthopedic - One or both uppers or lowers	130	307	12583*	11.8%
Orthopedic - Other	71	214	8761*	8.2
Absence or Amputation of Members	65	97	300	.3%
Psychotic Disorders	161	313	1169*	1.1%
Psychoneurotic Disorders	147	419	1569*	1.5%
Other Mental Disorders	219	1244	4662*	4.4%
Mild Mental Retardation	149	352	3700	3.5%
Moderate Mental Retardation	157	286	3004	2.8%
Severe Mental Retardation	37	66	696	.7%

[1] The blind are rehabilitated by the State Board of Education and Services for the Blind.

*The estimated eligible were grouped together in general categories. These general categories were then broken down in accordance with the proportions found in the 1967 active case load.

Disability Categories	No. Regabilitated Fiscal Year, 1967	No. in the Nov. 67 Active Case load	Estimated Eligible 1967	% of the Total Estimated Eligible
Cancer	2	8	**	--
Allergic, Endocrine, Metabolic, or Nutritional Disorders	16	47	6100	5.7%
Diseases of the Blood	1	8	**	--
Epilepsy	32	97	700	.7%
Other Disorders of Nervous System	5		**	--
Cardiac Conditions	59	144	17500	16.5%
Other Circulatory Conditions	7		6100	5.7%
Respiratory Diseases	59	111	4900	4.6%
Digestive System Disorders	20	33	8300	7.8%
Genito-Urinary System Conditions	0	5	4100	3.9%
Speech Impairments	24	41	1000	.9%
Others (not elsewhere classified)	13	55	**	--
Totals	1,715	4,249	106,200	100%

**No estimates are available.

Sources of Data: Summary of rehabilitated, 66-67, and active case load, Nov. 67, State of Connecticut, Division of Vocational Rehabilitation; the estimates of those eligible for vocational rehabilitation services was derived from several sources: The Chronic Illness Control and Health of the Aging Activities in Connecticut, 1965-1969, prepared by the State Department of Health; Chronic Conditions and Activity Limitation, United States, July 1961-June 1963, prepared by the U. S. Department of Health, Education, and welfare from the National Health Survey; and Correspondence with public and private agencies concerned with the problems of disabilities and rehabilitation.

In recent years the techniques of cost-benefit analysis have been used to measure the effectiveness of many governmental programs. Although the cost-benefit techniques were originally used in evaluation of water resource and other projects, the techniques have been recently applied to investments in programs dealing with improvement of human resources such as Vocational Rehabilitation, Job Corps, and Upward Bound.

The results achieved by Vocational Rehabilitation lend themselves to measurement by these techniques. It is possible to evaluate partially the improvement of a person who has been rehabilitated. The benefits inherent in this improvement accrue to the individual rehabilitant, to the taxpayer who may be relieved of a tax burden, and to the economy as a whole which benefits from the increased productivity of rehabilitated persons. Benefits to the individual, to the taxpayer, and to the economy and their associated costs are reviewed in the following pages.

The benefits which accrue to the individual as a result of Vocational Rehabilitation are represented by the achievement of a gainful occupation which can be measured quantitatively and the possible improvements in physical adaptation, personal adjustment, educational development, economic condition, and communication skills which are qualitative benefits.

The costs involved for the individual rehabilitant in attaining these economic and personal benefits are small. The average length of time which a rehabilitated client spends on the rolls of the Connecticut Division of Vocational Rehabilitation is 1 1/6 years. During this period of time the rehabilitant could have chosen to remain on the rolls of a public assistance agency or in the custodial care of a public institution. It is possible that during this period of rehabilitation training or retraining he is prevented from earning any income so that he must subsist on the maintenance allowances provided by Vocational Rehabilitation or allowances from his family or friends.

Since the personal benefits received by rehabilitated clients cannot be measured in dollar values, the technique most commonly used to measure benefits is the computation of the increase in lifetime earnings which has resulted from Vocational Rehabilitation services. As shown in the following table, there is a sharp increase in the lifetime earnings of the rehabilitated. The calculation of these lifetime earnings has been made for the 1547 clients rehabilitated in Connecticut in Fiscal Year 1966-1967. (The same procedure will be followed for the 1967-1968 data which is presently being compiled.)

Description of Table I

Part I of Table I includes the lifetime earnings of:

1390 clients who entered the competitive labor market
78 who entered sheltered workshops
13 who became self-employed
1 who entered a state agency managed business

Part II of the table shows projected lifetime earnings for 227 clients who were working and earning incomes at the time of their acceptance into the Vocational Rehabilitation program. It is assumed that these earnings would have continued without the benefit of Vocational Rehabilitation.

Part III and IV of the table show the estimated lifetime dollar value of the work activity at closure and at acceptance of:

56 homemakers
7 unpaid family workers

Estimated Lifetime Earnings[*] and Service Values For Rehabilitated Clients

At Acceptance and at Closure

		Dollar Amount	
I	Lifetime earnings of rehabilitated clients based on earnings at closure (other than homemakers and unpaid family workers)	+86,360,000	
II	Lifetime earnings of rehabilitated clients based on earnings at acceptance (other than homemakers and unpaid family workers)		-5,930,000
III	Estimate of value of service rendered by homemakers and unpaid family workers at closure	+ 1,570,000	
IV	Estimate of value of services rendered by homemakers and unpaid family workers at acceptance		- 70,000
	Net Increase in lifetime earings	+81,930,000	

---

[*] The data represent 1547 clients rehabilitated in 1966-1967 in Connecticut. The method used for deriving these estimates is available upon request.

Figures rounded to the nearest ten thousand.

The benefits to the taxpayer occur in the form of reduced dependency on Public Assistance and reduction of the number of those who are in public institutions such as mental hospitals and sanitoria. The decrease of dependence on Public Assistance which amounted to $121,404 per year for the 1966-1967 **rehabilitated** clients must be considered for an extended period of time. If the savings in Public Assistance is based on a five year period, then the total dollars saved amounts to $607,020.

Of the clients rehabilitated in 1967, 182 came from various public institutions. The cost of maintaining this group in public institutions was approximately $54,000 per month. The average length of time rehabilitated clients would have spent in an institution if it were not for VR is not definitely known, however, if one year is taken as the average, the savings would amount to $650,000.

The cost to the taxpayer is his contribution in taxes to support the rehabilitation program.

The operation of the Connecticut Labor Market benefits because of the wide spectrum of occupations which rehabilitants enter or return to. Those occupations include, for instance, the machine trades which are presently very much in need of qualified persons. The cost to employers is represented by that portion of their tax bill which supports the work of Vocational Rehabilitation.

The effect of Vocational Rehabilitation on the Gross National Product occurs primarily as the result of the additional lifetime earnings of the rehabilitated clients. These earnings of the 1966-1967 rehabilitated resulted in additional consumption, annual increased income tax of $445,800, and yearly increased sales tax revenues of $26,700. The increase in the Gross National Product benefits all members of the economy.

Summary of Questionnaires to Personnel in Social and Rehabilitation Services in Connecticut - 1968

This report is a summary of the questionnaires sent to personnel in social and rehabilitation services in Connecticut. The purpose of the questionnaires was to obtain information and opinions on the expansion of vocational rehabilitation services in Connecticut through 1975. The survey was completed by eighty-five administrative and two hundred and six operating personnel in social and rehabilitation services in Connecticut. The questionnaires furnish documentation for expansion or improvement in several areas: finances, client services, personnel, public relations and facilities.

Finances:

The eighty-five administrative respondents ranked inadequate funding as the second greatest source of problems in their agencies. Provision for better financial backing is the legislation they would most like to see passed.

The need for more money also seems to be reflected by the fact that agencies have trouble retaining professional workers. The administrative respondents ranked as the most frequent reason given by professional staff when they leave: a position offering more money.

Only 35% of the operating respondents indicated that their agencies are able to offer better salary as an incentive for staff to further their education.

Client Services:

There seems to be some unmet need for training and retraining of clients. The mean percentage of clients whom operating respondents feel need training or retraining before they can return to work is 39.8%; however, respondents' agencies give training or retraining as a part of their services to a mean of 33.1% of clients.

There is also a need for more follow-up. 49% of the operating respondents replied that they follow up some cases, but of this 49%, 76% follow up only one-fourth or less of their cases. 24% of the operating respondents close their cases if the client is referred to another agency.

Both administrative and operating respondents felt that unneeded procedures and restrictions hindered the flow of services to the client. 17% of the operating respondents felt that DVR eligibility requirements delayed or prevented services to their clients. Less complication in governmental procedures to allow benefits to go to the disabled faster ranked as the third item administrative respondents would most like to see passed into legislation.

24% of the operating respondents thought that clients' transportation problems delayed or prevented rehabilitation services to them.

Personnel:

The operating respondents as counselors and caseworkers bear most of the responsibility for their cases. 69% have complete responsibility or complete responsibility with some supervisor consultation. This individualized responsibility makes the training of these professionals of paramount importance. However, the questionnaires indicate that training could be improved.

21% of the operating respondents thought that some, but not much or very little knowledge gained in the classrooms is relevant to their positions. 66% thought that quite a bit is relevant but more is learned on the job. Therefore, in-service training programs are very important and 21.5% of the operating respondents said that their agencies do not have such training.

16% of the operating respondents spend no time on their professional advancement. 39% of the operating respondents and 19% of the administrative respondents are not allowed to take time off to further their professional skills.

36% of the administrative respondents thought that beginning professional workers were weak in counseling and guidance. 27% thought that there was a weakness in case reporting. 25% thought there was a weakness in placement. 24% thought there was a weakness in each of these areas: social work, abnormal psychology, and interviews. 22% thought new professionals were weak in public relations and 21% thought they were weak in vocational evaluation. Administrative respondents thought professionals should have had more course work in all the areas in which they were weak.

"More programs to train professional staff," was ranked second as needed legislation by administrative respondents. They ranked "untrained professional staff as the third greatest source of problems for them or for their agencies. They felt that better qualified or trained professional staff was the second greatest need for their agencies in 1970 and in 1975.

Insufficient professional staff was ranked as the greatest source of problems by the administrative respondents. They ranked more professional staff as the greatest need for 1970 and 1975. The administrative respondents ranked "insufficient clerical staff" as the fourth source of problems for them or for their agencies.

The growth trend of the agencies demands, and will continue to demand, more personnel. If the number of staff members in two categories in 1965 is taken as the base, with an index of one, for each category, the projected growth can be seen.

	Professional Staff	Clerical Staff
1965	1	1
1968	1.7	1.2
1970	2.2	1.4
1975	2.3	1.6

In 1965 the ratio of professional employees to clerical employees was 1.2 to 1 or 1.2 professional employees for every clerical employee, and the ratio of professional employees to clerical employees in 1975 will be 1.7 to 1 according to this projection. The counselor or case worker respondents presently spent 27.8% of their time on duties of a clerical or reporting nature, and if the clerical force does not increase more than is here projected, they are likely to be spending even more time on clerical duties. The administrative respondents ranked "more clerical staff" as the third greatest need for their agencies in 1970 and in 1975. 12% of the operating respondents said that the lack of vocational rehabilitation counselors delayed or prevented services to their clients.

Public Relations:

There also seems to be a definite need for more public relations. 78% of the administrative respondents and 96% of the operating respondents said that the general public knows the function of the Division of Vocational Rehabilitation only some or very little. 62% of the operating respondents felt that the general public knows very little about the function of the vocational rehabilitation agencies.

Facilities:

The mean percentage of clients whom operating respondents refer to sheltered workshops or evaluation workshops is 10.7%. The mean percentage of clients whom operating respondents feel could use the facilities of a sheltered workshop or an evaluation workshop if it were available is 22.2%. 64% of the operating respondents have had good experiences with sheltered workshops or evaluation workshops and rehabilitation centers. However, three out of four said that the staffs were cooperative but that there were time and space problems. 36% of the operating respondents have had fair or poor experiences with sheltered workshops, evaluation workshops, and rehabilitation centers.

Note: This two-part questionnaire was adapted from one used in Arizona. We wish to thank Mr. Gerald McCue, Director of the Statewide Planning Project in Arizona for his kindness in allowing us to use it.

CLASSIFICATION OF DISABLING CONDITIONS AND CAUSES

VRA Code	
(1--)	VISUAL IMPAIRMENTS
(10-)	Blindness, both eyes, no light perception, due to:
100	cataract
101	glaucoma
102	general infectious, degenerative, and other specified diseases, including ocular and local infections
106	congenital malformations
107	accident, poisoning, exposure or injury
109	ill-defined and unspecified causes
(11-)	Blindness, both eyes (with correction not more than 20/200 in better eye or limitation in field within 20 degrees, but not VRA 10), due to:
110	cataract
111	glaucoma
112	general infectious, degenerative, and other specified diseases, including ocular and local infections
116	congenital malformations
117	accident, poisoning, exposure or injury
119	ill-defined and unspecified causes
(12-)	Blindness, one eye, other eye defective (better eye with correction less than 20/60, but better than 20/200, or corresponding loss in visual field), due to:
120	cataract
121	glaucoma
122	general infectious, degenerative, and other specified diseases, including ocular and local infections
126	congenital malformations
127	accident, poisoning, exposure or injury
129	ill-defined and unspecified causes
(13-)	Blindness, one eye, other eye good, due to:
130	cataract
131	glaucoma
132	general infectious, degenerative, and other specified diseases, including ocular and local infections
136	congenital malformations
137	accident, poisoning, exposure or injury
139	ill-defined and unspecified causes

Classification of Disabling Conditions and Causes - 2

VRA Code	
(14-)	Other visual impairments, due to:
140	cataract
141	glaucoma
142	general infectious, degenerative, and other specified diseases, including ocular and local infections
146	congenital malformations
147	accident, poisoning, exposure or injury
149	ill-defined and unspecified causes
(2--)	HEARING IMPAIRMENTS
(20-)	Deafness, unable to talk, due to:
200	degenerative and other non-infectious and specified diseases of ear
202	upper respiratory infections and other infectious diseases
206	congenital malformations
208	accident, poisoning, exposure or injury
209	ill-defined and unspecified causes
(21-)	Deafness, able to talk, due to:
210	degenerative and other non-infectious and specified diseases of ear
212	upper respiratory infections and other infectious diseases
216	congenital malformations
218	accident, poisoning, exposure or injury
219	ill-defined and unspecified causes
(22-)	Other hearing impairments, due to:
220	degenerative and other non-infectious and specified diseases of ear
222	upper respiratory infections and other infectious diseases
226	congenital malformations
228	accident, poisoning, exposure or injury
229	ill-defined and unspecified causes

Classification of Disabling Conditions and Causes - 3

VRA Code	
(3--)	ORTHOPEDIC DEFORMITY OR FUNCTIONAL IMPAIRMENT, EXCEPT AMPUTATIONS
(30-,31-)	Impairment involving three or more limbs or entire body, due to:
300	cerebral palsy
301	congenital malformation or other and ill-defined birth injury
303	other diseases, infectious and non-infectious (excluding VRA 646, varicose veins), other infections (including local), and other neurological and mental diseases (excluding VRA 630, epilepsy)
310	arthritis and rheumatism
312	intracranial hemorrhage, embolism and thrombosis (stroke)
314	poliomyelitis
315	muscular dystrophy
316	multiple sclerosis
317	Parkinson's disease
319	accidents, injuries, and poisonings
(32-,33-)	Impairment involving one upper and one lower limb (including side), due to:
320	cerebral palsy
321	congenital malformation or other and ill-defined birth injury
323	other diseases, infectious and non-infectious (excluding VRA 646, varicose veins), other infections (including local), and other neurological and mental diseases (excluding VRA 630, epilepsy)
330	arthritis and rheumatism
332	intracranial hemorrhage, embolism, and thrombosis (stroke)
334	poliomyelitis
335	muscular dystrophy
336	multiple sclerosis
337	Parkinson's disease
339	accidents, injuries, and poisonings
(34-,35-)	Impairment involving one or both upper limbs (including hands, fingers, and thumbs), due to:
340	cerebral palsy
341	congenital malformation or other and ill-defined birth injury
343	other diseases, infectious and non-infectious (excluding VRA 646, varicose veins), other infections (including local), and other neurological and mental diseases (excluding VRA 630, epilepsy)
350	arthritis and rheumatism
352	intracranial hemorrhage, embolism, and thrombosis (stroke)
354	poliomyelitis
355	muscular dystrophy
356	multiple sclerosis
357	Parkinson's disease
359	accidents, injuries, and poisonings

Classification of Disabling Conditions and Causes - 4

VRA Code	
(36-,37-)	Impairment involving one or both lower limbs (including feet and toes), due to:
360	cerebral palsy
361	congenital malformation or other and ill-defined birth injury
363	other diseases, infectious and non-infectious, (excluding VRA 646, varicose veins), other infections (including local), and other neurological and mental diseases (excluding VRA 630, epilepsy)
370	arthritis and rheumatism
372	intracranial hemorrhage, embolism, and thrombosis (stroke)
374	poliomyelitis
375	muscular dystrophy
376	multiple sclerosis
377	Parkinson's disease
379	accidents, injuries, and poisonings
(38-,39-)	Other and ill-defined impairments (including trunk, back, and spine), due to:
380	cerebral palsy
381	congenital malformation or other and ill-defined birth injury
383	other diseases, infectious and non-infectious, (excluding VRA 646, varicose veins), other infections (including local), and other neurological and mental diseases (excluding VRA 630, epilepsy)
390	arthritis and rheumatism
392	intracranial hemorrhage, embolism, and thrombosis (stroke)
394	poliomyelitis
395	muscular dystrophy
396	multiple sclerosis
397	Parkinson's disease
399	accidents, injuries, and poisonings
(4--)	ABSENCE OR AMPUTATION OF MAJOR AND MINOR MEMBERS
(40-)	Loss of at least one upper and one lower major extremity (including hands, thumbs, and feet), due to:
400	malignant neoplasms
402	congenital malformation
404	diseases, infectious and non-infectious (including peripheral vascular, diabetes, tuberculosis of bones and joints), and infections (including gangrene)
409	accidents, injuries, and poisonings

Classification of Disabling Conditions and Causes - 5

VRA Code	
(41-)	**Loss of both major upper extremities (including hands or thumbs), due to:**
410	malignant neoplasms
412	congenital malformation
414	diseases, infectious and non-infectious (including peripheral vascular, diabetes, tuberculosis of bones and joints), and infections (including gangrene)
419	accidents, injuries, and poisonings
(42-)	**Loss of one major upper extremity (including hand or thumb), due to:**
420	malignant neoplasms
422	congenital malformation
424	diseases, infectious and non-infectious (including peripheral vascular, diabetes, tuberculosis of bones and joints), and infections (including gangrene)
429	accidents, injuries, and poisonings
(43-)	**Loss of one or both major lower extremities (including feet), due to:**
430	malignant neoplasms
432	congenital malformation
434	diseases, infectious and non-infectious (including peripheral vascular, diabetes, tuberculosis of bones and joints), and infections (including gangrene)
439	accidents, injuries, and poisonings
(44-)	**Loss of other and unspecified parts (including fingers and toes, but excluding thumbs), due to:**
440	malignant neoplasms
442	congenital malformation
444	diseases, infectious and non-infectious (including peripheral vascular, diabetes, tuberculosis of bones and joints), and infections (including gangrene)
449	accidents, injuries, and poisonings
(5--)	MENTAL, PSYCHONEUROTIC, AND PERSONALITY DISORDERS
(50-)	**Psychotic disorders**
500	Psychotic disorders

Classification of Disabling Conditions and Causes - 6

VRA Code		
(51-)		Psychoneurotic disorders
510		Psychoneurotic disorders
(52-)		Other mental disorders
520		alcoholism
521		drug addiction
522		other character, personality, and behavior disorders
(53-)		Mental Retardation
530	1/	mental retardation, mild
532	1/	mental retardation, moderate
534	1/	mental retardation, severe

1/ The Classification and Coding of Mental Retardation

The definition of mental retardation used by VRA was developed in 1961 by the American Association on Mental Deficiency, and this is the one most generally accepted in the United States today. This reads as follows:

> Mental retardation refers to sub-average intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior. This may be reflected in impairment of:
>
> a. Maturation: rate of sequential development of self-help skills of infancy and early childhood
>
> b. Learning: the facility with which knowledge is acquired as a function of experience
>
> c. Social Adjustment: the degree to which the individual is able to maintain himself independently in his environment

Classification of Disabling Conditions and Causes - 7

VRA Code	
(6--)	OTHER DISABLING CONDITIONS - ETIOLOGY NOT KNOWN OR NOT APPROPRIATE
(60-)	Other conditions resulting from neoplasms (n.e.c.):
600	colostomies resulting from malignant neoplasms
601	laryngectomies resulting from malignant neoplasms
602	leukemia and aleukemia
605	other malignant neoplasms
609	benign and unspecified neoplasms
(61-)	Allergic, endocrine system, metabolic and nutritional diseases:
610	hay fever and asthma
611	other allergies
614	diabetes mellitus
615	other endocrine system disorders
619	avitaminoses and other metabolic diseases
(62-)	Diseases of the blood and blood-forming organs:
620	haemophilia
629	anaemia and other diseases of the blood and blood-forming organs (except VRA 602, leukemia and aleukemia)
(63-)	Other specified disorders of the nervous system:
630	epilepsy
639	other disorders of the nervous system, n.e.c.
(64-)	Cardiac and circulatory conditions:
640	congenital heart disease
641	rheumatic fever and chronic rheumatic heart disease
642	arteriosclerotic and degenerative heart disease
643	other diseases or conditions of heart
644	hypertensive heart disease
645	other hypertensive disease
646	varicose veins and hemorrhoids
649	other conditions of circulatory system
(65-)	Respiratory diseases:
650	tuberculosis of the respiratory system
651	emphysema
652	pneumoconiosis and asbestosis
653	bronchiectasis
654	chronic bronchitis and sinusitis
659	other diseases of respiratory system

Classification of Disabling Conditions and Causes - 8

VRA Code	
(66-)	Disorders of digestive system:
660	conditions of teeth and supporting structures
661	ulcer of stomach and duodenum
662	chronic enteritis and ulcerative colitis
663	hernia
664	colostomies (from other than malignant neoplasms)
669	other conditions of digestive system
(67-)	Conditions of genito-urinary system:
670	conditions of genito-urinary system
(68-)	Speech impairments:
680	cleft palate and harelip with speech imperfections
682	stammering and stuttering
684	laryngectomies (from other than malignant neoplasms)
685	aphasia resulting from intracranial hemorrhage, embolism, or thrombosis (stroke), other speech impairments (except VRA 685, aphasia resulting from stroke)
(69-)	Disabling diseases and conditions, n.e.c:
690	diseases and conditions of the skin and cellular tissue, n.e.c.
699	other disabling diseases and conditions, n.e.c.

VOCATIONAL REHABILITATION SYSTEM

STANLEY YOUNG, Ph.D, PROFESSOR OF MANAGEMENT

UNIVERSITY OF MASSACHUSETTS

AMHERST, MASSACHUSETTS

VOCATIONAL REHABILITATION SYSTEM

STANLEY YOUNG, Ph.D, PROFESSOR OF MANAGEMENT
UNIVERSITY OF MASSACHUSETTS
AMHERST, MASSACHUSETTS

The comments on vocational rehabilitation which follow give consideration to:

1. The Present Service System
2. The Management System
3. Functional Analysis of Rehabilitation
4. The Evaluation System
5. Program Planning and Budgeting Systems

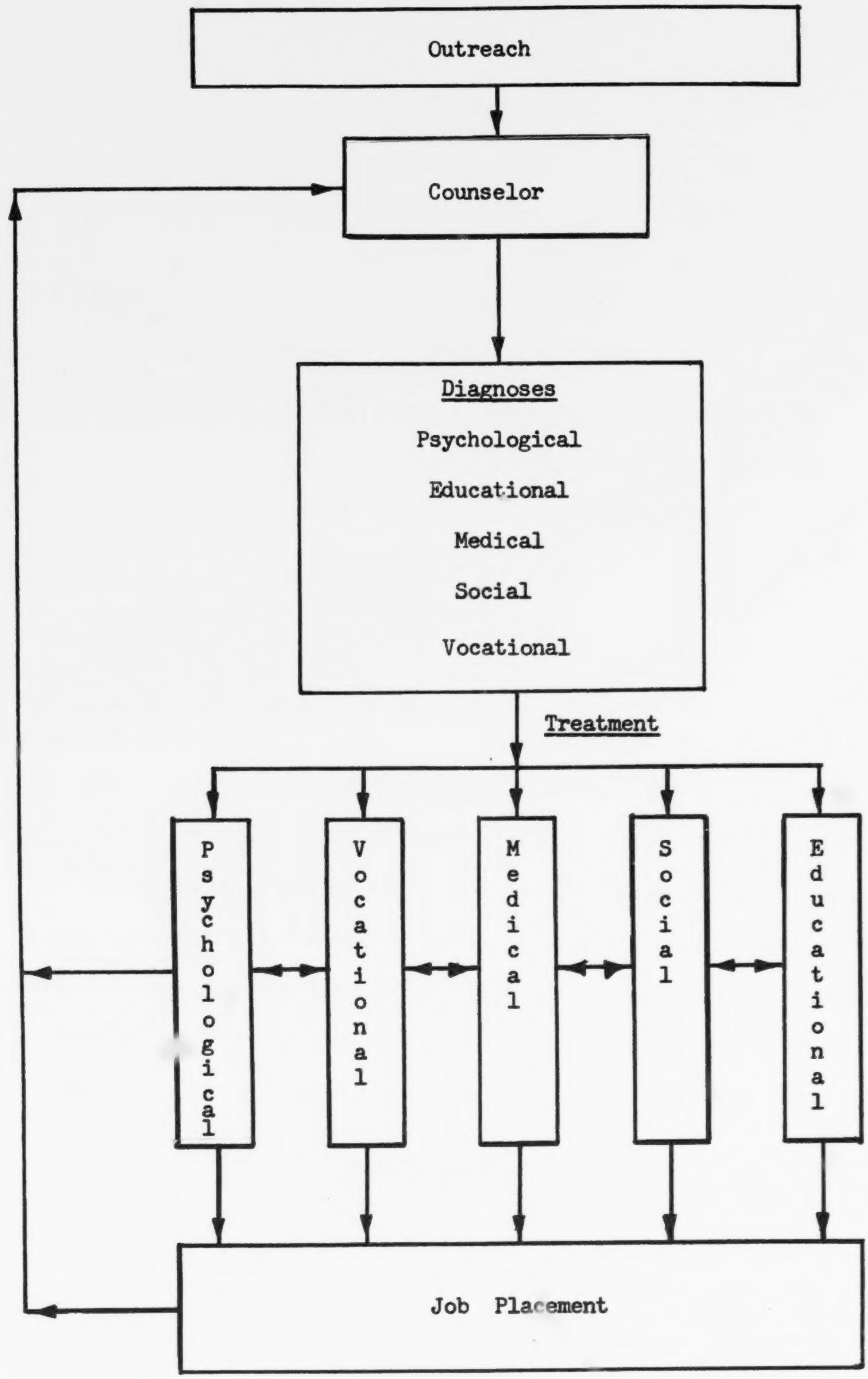
A broad analysis, as it relates to vocational rehabilitation, will be presented. We shall attempt to block out relatively large operational units and to show their inter-related functions. This report is intended for discussion purposes, and when more specific strategy is developed as to which areas will receive particular focus, greater detail can be generated. This report should, therefore, be viewed as being highly speculative, its essential purpose to extend the boundaries of ways in which we might view the potential development of a vocational rehabilitation system. Note that a vocational rehabilitation system will be regarded from a number of different points of view, and a variety of analogues will be utilized to provide different conceptual frameworks.

THE MODEL SERVICE SYSTEM

A system analysis of the rehabilitation system, it seems to me, starts logically with the basic operation of the system, or the role of the counselor. We might look briefly at Chart I, Model Client Service

CHART I

PRESENT CLIENT SERVICE SYSTEM


Outreach
Counselor
Diagnoses
Psychological
Educational
Medical
Social
Vocational
Treatment
Psychological
Vocational
Medical
Social
Educational
Job Placement

System, and note, at the outset, that it is an outreach mechanism or referral device by which the potential client who requires some form of rehabilitation is referred to the counselor. The rehabilitation counselor then has the client's difficulties diagnosed. These can be physical, psychological, educational, social, etc. Once the specific deficiency is determined, then the appropriate treatment is prescribed. Upon its successful completion, the client is directed, through a job placement process, to such jobs as he may successfully perform, and these are searched for. Finally, he is put into a job, and closure occurs.

In looking at this particular service system, its most significant aspect is that the counselor, while having the responsibility to assure that rehabilitation occurs, does not himself provide the rehabilitation. The counselor's responsibility is to refer the client to the appropriate diagnostic treatment and placement agencies and arrange to pay for rehabilitation. It is this referral, monitoring, evaluating aspect which gives the counselor and the rehabilitation system its most distinctive characteristic.

The most appropriate analogue, in terms of the counselor's role, is that of the physician in general practice. Note the relationship of the patient to his physician as the patient is processed through the hospital. The hospital has available for the patient a set of diagnostic and treatment capabilities in the form of expert personnel and equipment. Here one has specialists on the running and interpretation of the tests in the form of radiologists and hematologists who interpret the results of the diagnosis for the physician. The physician acts basically as a referral mechanism to the other specialties. The patient may enter the hospital amd his doctor may prescribe a series of tests. These tests are returned to the physician in the form of a diagnosis. The diagnosis, itself, will suggest certain treatments. The physician, on the basis of the diagnosis, will prescribe treatments which are performed by surgeons, neurologists, psychiatrists, etc. The physician is in constant communication with the specialists and they mutually agree on the appropriate treatment. Further, the physician is in constant communication with the patient and his family, assuring that the patient is receiving the proper treatment. The personal confidence of the patient is placed in the family physician and the patient is assured a health service system which is highly technical. The client will be processed through this health system by a close, personable, knowledgeable individual who is the family physician.

Why is this an effective procedure, and why is the general practitioner essential in the process? Clearly, in something as complicated and technical as the present health system, we could not reasonably expect the patient to process himself through such a system. He neither knows what his needs are nor what the appropriate treatment should be. We realize that, from the patient's point of view, every treatment is unique. One cannot administratively set up a uniform health service system in which every patient who enters the hospital receives exactly the same treatment. It is essential that there be a connecting link between the health service system and the patient -- someone who will guide the patient properly through the system and connect the highly specialized technical capability of that system to the patient. The general physician is, essentially, a material handler in this case, and the patient is the material. Important decisions have to be made as to what specific work processes the material, or patient, will go through to assure successful treatment. The physician acts as a representative of the patient, thus assuring him that the system will work to his benefit. In other words, the patient requires a representative of his interests vis-à-vis the system, to assure that the system will not exploit the patient. While the specialist might be able to manipulate the patient, the specialist is not able to manipulate another specialist who has sufficient general knowledge to ascertain the significance of the various services which are being offered to the patient. The general practitioner, in the setting of the health system, may be looked upon as a health counselor, and provides three essential functions or services in terms of the client and the system:

1. He matches client need and the service system capability.
2. He acts as the patient's representative in the health system to protect the patient's interest, and assure that the system serves the patient, rather than the patient serving the system.
3. He acts as an integrating device, in that the patient moves from health procedure to health procedure in terms of correcting the illness.

The rehabilitation counselor can be viewed much as the general practitioner physician, in the sense that the counselor performs the same essential service for the client. We might look at Chart I , Model Client Service System, and note that the client may have a variety of deficiencies which require treatment. The counselor sends the client to various diagnostic agencies to ascertain whether the specific deficiencies are educational, social, medical, economic, psychological, or vocational. The client may suffer from one or all of these. Along with the diagnosis, obviously, certain treatment is prescribed to which the counselor then sends the client. That is, medical, social, psychological, educational, or vocational corrections may occur in a certain prescribed sequence, performed by different agencies in different time periods. At the end of the diagnostic and treatment process, the specific deficiencies of the client will have been ascertained and, ideally, appropriate treatment prescribed so that definciencies are eliminated, whether they be medical or vocational. Finally, the counselor assures that the client, his deficiency corrected within the capability of current technology, is placed on a job, is self-sufficient and, viewed from a societal point of view, is considered rehabilitated and a part of the normal, productive population.

There are several interesting aspects to the counselor's role and the rehabilitation system, in general. First, under present rehabilitation legislation, client deficiencies are viewed in a much wider sense than being purely medical in nature. Thus, the client may need much more extensive diagnosis and treatment. Another interesting aspect is that the counselor himself does not perform the diagnosis or the treatment and should not do so. One must assume that there is, in the community, a set of specialists, both in the technical and the agency sense, which can effectively perform diagnosis and treatment. Obviously, the counselor cannot practice medicine. Complicating his job, however, is the fact that the particular capabilities which he will try to match to his client's needs, in the community, are not assembled in one central location, as in the hospital. In general, the physician will have, in one central location, the diagnostic and treatment process which he requires. However, as far as the counselor is concerned, these may be scattered throughout the community, so that, for diagnosis and treatment, he may have to send the client to a variety of different agencies located at different points in the community. If the counselor is to perform his job effectively, he must have sufficient knowledge of what diagnostic and treatment capabilities exist in the community, and what particular matches should be made between specific diagnosis and treatment vis-à-vis the various medical, educational, vocational, and psychological categories with which he will be dealing. Just as the physician in the hospital must have some knowledge of what specific diagnosis and treatment are, and what parts of the medical capability should be utilized for a specific individual, so the counselor must have the necessary knowledge because he faces the same essential problem of matching the client's needs to community and agency capability in the form of diagnosis and treatment. This knowledge would not only be difficult to acquire in a static situation but, as new community programs and technology develop, it means that community capability is changing and, presumably, the counselor would have to keep up with these changes. This particular problem should be looked at more critically when we look at the management system.

A counselor also acts as the representative of the client through the system. As the client moves from the diagnostic agency to treatment, to placement, to the job, one assumes that the client remains in contact with the counselor, and that the agencies understand that the counselor is going to represent the interests of the client, so that the client receives the necessary services. Moreover, if the client is unhappy about services received, then, presumably, the counselor represents the grievance agent who will deal with the professionals in the system in resolving the problem. Finally, of particular significance, the counselor represents the material-handler through the community service system, assuring that the client moves from service to service and is not lost in the system. The counselor, from the client's point of view, represents the essential integrating device as far as community services are provided. For example, the counselor may send the client, initially, to a hospital for a certain diagnosis. On the basis of that diagnosis, the counselor may send the client to another health facility for treatment, at the end of which the client may be sent to an educational facility, then to placement. Later, the counselor will assure that when the client is placed on a job, there will be continual follow-up. Thus, we find that the counselor performs, in a more general way, the same set of activities as the general practitioner:

1. He matches the need of the client with the capabilities of the community service system.
2. He acts as the client's representative vis-à-vis the professionals of the service system and assures that service is provided.
3. He is the material handler, or integrating device, as far as the client is concerned.

One aspect which derives from this unique role is that the counselor is in an unusual position to monitor the client's progress, in terms of the community service system. Just as the general practitioner has to determine whether his patients receive proper care as they are processed through the health system, so the counselor has to make similar evaluative judgments about his clients as they are processed through the community service system.

Assuming that the above analogue is appropriate, what conclusions can one draw about the rehabilitation system, and the unique role and set of services which the counselor or counseling unit provides? The rehabilitation system in Connecticut consists of more than sixty counselors throughout the State. While there are other activities being performed, it is really the counselor who represents the heart of the system. The first conclusion relates to the know-how which one assumes the counselor has.

The counselor, as is true with the general practitioner in medicine, is a kind of general practitioner in community services, and should have sufficient knowledge as to proper diagnosis and treatment, although the counselor himself is not a specialist. The counselor should be able to deal with the specialist on a reasonably sophisticated level. The counselor does not provide services directly to the client, as it is not the role of the counselor to diagnose and provide treatment.

In the literature, there is a tendency to see the counselor in a psychological sense, in that he may perform certain psychological diagnoses and attempt to provide personal clinical therapy. This may derive from the need to set up an acceptable social relationship between the counselor and the client, one of trust and confidence. However, the trust, acceptance, and the confidence that a client has in his counselor will not derive from this pseudo-psychological effort, but rather from the technical know-how of the counselor as he provides the proper services and represents the client as he progresses through the service system. Obviously, there are trained, qualified psychological clinicians in the community who can both diagnose and treat, and it is not the role of the counselor to attempt to do this. As a matter of fact, there might be a question of ethics raised here. The counselor's role is a fairly straightforward but highly complicated one.

Another conclusion can be drawn, one on which this report will place special emphasis as it relates, particularly, to the long run development of the rehabilitation system. The rehabilitation system is the only well-established community agency in which the essential function of the agency itself, in the role of counselor, is to perform the activities as noted:

1. Match the client need and community service
2. Represent the client vis-à-vis the service
3. Integrate the service in terms of processing the client through the service

Integration can be identified as the counselor acting as a coordinator of services. Various other programs have attempted to get at the solution of this problem, but, as yet, rather unsuccessfully.

The Office of Economic Opportunity has established, particularly under the Community Action section of the legislation, a coordinated attack on poverty. Model Cities, in its planning stage, has this same thrust. In the health area, one finds both the concept of community health centers and mental health centers, which are attempts to get at the same problem of coordination at the community level. To my knowledge, none of these has been particularly successful.

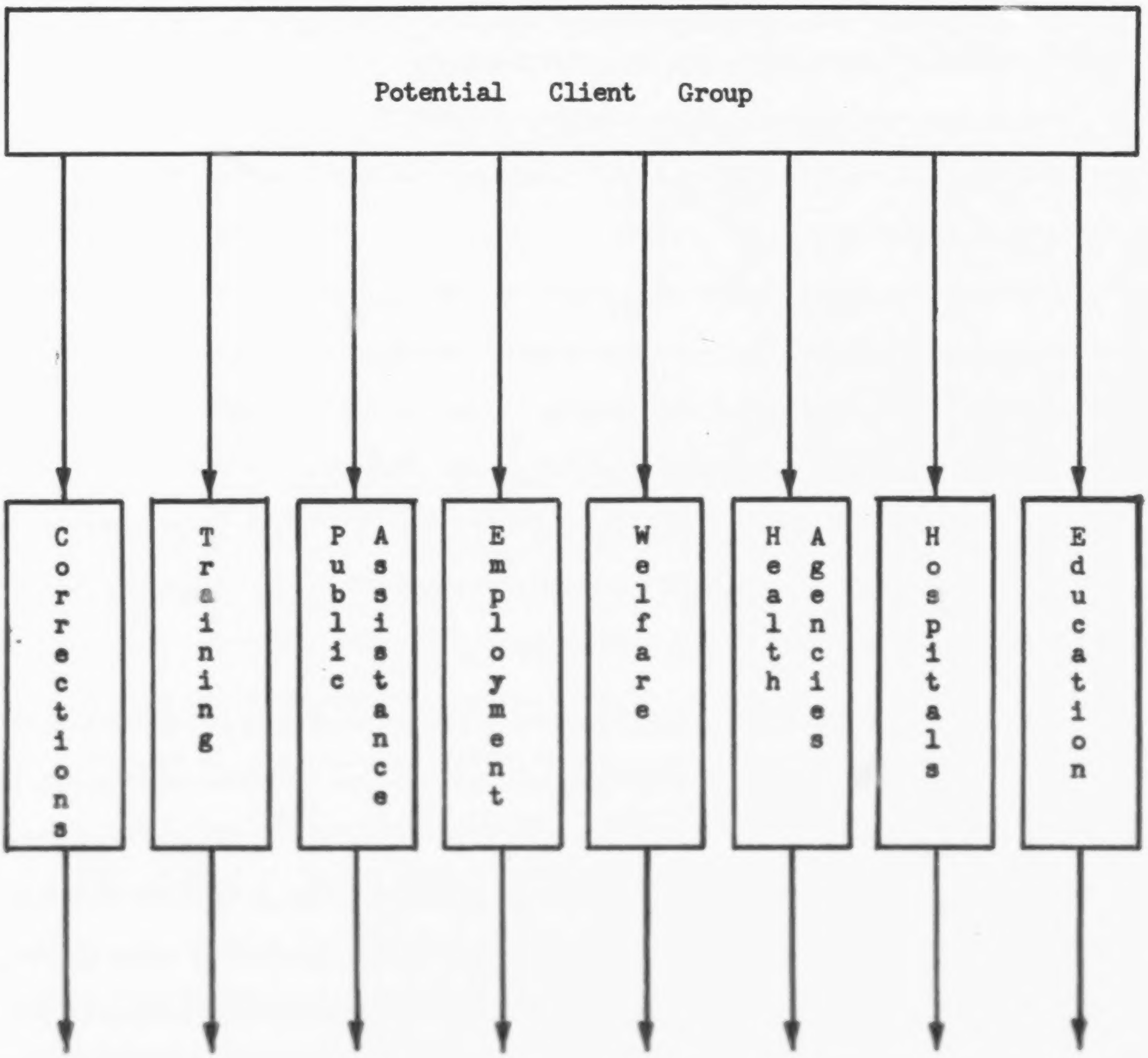
The need for more effective integration and coordination in terms of the delivery of community services to the potential client group is one of the most widely discussed problems in the literature. One finds, in articles and speeches and conferences, constant stress on agency coordination. This is quite clear at the Federal level, as recent legislation of Model Cities and health programs have this as a central focus. The difficulty is at the individual client level. We have very little idea of the nature of the problem of coordination or its solution; at least, as it expresses itself in the literature. All one really finds is that people are saying we need more effective coordination and integration of service systems to assure that the right people receive the right services, to avoid duplication, and to assure efficiency, etc., but little work and analysis of the essential nature of the problem. What I am suggesting is that the rehabilitation system constitutes a solution to this problem and, as a long run development effort, should be extended to the total community service system. As a matter of fact, the rehabilitation system represents the only viable solution that we are aware of and which works effectively, performs what we want done (the ultimate job placement of the client group), and has a history of accomplishing this successfully. The dilemma, of course, is that the rehabilitation system is restricted to an extremely small segment of the potential client group. Most of the community service system is operating without the counselor, or integrating device, and doing it very poorly.

Therefore, in terms of "selling" the rehabilitation system as a whole, at the State level, vis-à-vis the competition of other agencies, it is important to establish the kind of essential service the rehabilitation system provides and to point out that this service is not provided by any other agency. There is a widespread recognition of its need, and so it should constitute a more essential aspect of a total community service system; in this sense, it should be supported, greatly expanded, and tied to a totally integrated community service system. I have a feeling that individuals in the rehabilitation agencies do not understand what it is that they are doing, and others outside the agency really don't, either. Until the unique set of activities which the counselor performs is presented to the legislature, it is unlikely that there will be an extensive expansion of the agency. Therefore, this unique service, which the rehabilitation system provides, has to be clearly delineated and presented to the potential buyer of the service.

In the absence of a rehabilitation capability, given any community service system, some very serious shortcomings emerge. This can be seen in Chart II, Present Client Service System. One can imagine a local community in which there is a set of agencies providing services, such as education, hospitalization, health, welfare, employment, public assistance, training, and correction. One can also assume that there exists a potential client group to be serviced by these agencies. In the absence of a unit such as rehabilitation, either it is assumed that members of the client group will seek out the agency for service and process themselves through the agency; or else, if the agency has a certain number to process, it will, itself, reach out into the community and get the required number of clients to justify its existence. Thus, for example, with Manpower Training and Development Programs, the local State or school unit will submit a project which requires funds from the Federal government, and then attempt to generate a sufficient number of trainees to justify its project. In the case of the educational system, whose service is compulsory, members of the client group are simply processed through the system until they are old enough to leave it. The basic criticism of such a service system, and one of which we are becoming increasingly aware, is that nothing is really happening. One has a set of agencies with a certain capacity and a certain technology, and clients are simply being processed through the several agencies. One has some idea of the number processed, but nothing is happening to the clients; they are just being processed through. There is little ultimate purpose, in terms of client needs being served. This is a completely dysfunctional system. What one really has is a system where the clients must frequently adjust to the particular service offered and the ultimate purpose of the service system is to serve the professional rather than client needs. It is an old story that correctional systems do no correcting. As a matter of fact, evidence exists that the manner in which they operate may actually lead to greater crime and a high level

CHART II

PRESENT CLIENT SERVICE SYSTEM


Potential Client Group
Corrections
Training
Public Assistance
Employment
Welfare
Health Agencies
Hospitals
Education

DIFFICULTIES:

1. No coordination or integration
2. No complete diagnosis
3. No follow-up monitor or evaluation
4. No outreach
5. Client must adjust to service system and serve professional ends.

of recidivism. There is no coordination or integration of service at the client level and, frequently, there is no diagnosis. The system is unable to cope with multiple deficiencies. If a person is ill, on welfare, has a poor education and a prison record, there is no unit which will both diagnose and lay out a total treatment program for this multiply-deficient client. As a result, he may be processed, for example, through a hospital but will still remain unemployed and unemployable. Frequently, one has no assurance that the actual service being provided is really the service he needs, because of the absence of effective and controlled diagnosis. There is no follow-up or monitoring or evaluation by another party, of the services performed. So, even in the context of what these agencies are doing, we frequently do not know, even in their own terms, if they are performing effectively. There is no effective outreach.

One can now compare Chart I , in which one has a rehabilitation capability, with Chart II , where one does not. The essential difference, of course, is that the counselor assures that diagnosis takes place and that treatment is directed toward diagnosis, rather than toward what the agency may have to offer. The program is integrated in terms of individual needs, and the possibility exists that, sequentially, the client with multiple deficiencies can be treated. The client is not lost, in the sense that one runs a training program for 17 weeks and processes 50 individuals through it who then disappear; or you have individuals drifting in and out of agency services. The client is not dropped until he has been placed in a job. In other words, the thing we find in the literature and which everyone is so concerned about, is the integration and coordination of the delivery of services to the multiply-handicapped individual, as provided now by rehabilitation. Most importantly, the capability exists of taking care of a multiply-deficient client. Quite clearly, a single treatment does not work; i.e., if one has an individual who is poorly educated, a subsidized on-the-job training program will not keep him employed.

There seems to be a critical combination of characteristics which an individual has to have in order to adjust successfully to society. In attempting to correct these, individually, or to allege that only one is important and one can ignore all the others, does not seem to be working at all. We do not really know what the sequence is, but in Chart II, we are assuming that, until some social and psychological skills or capabilities are developed, it is pointless to provide educational vocational programs.

In summary, both in terms of planning future development of the rehabilitation system and selling it, its unique set of services should be emphasized. It is not simply a question of asserting that by 1975, there will be many more individuals in the State of Connecticut who will require rehabilitation and that the budget ought to be increased. One would then be playing the "numbers game" which every agency can play. In 1975, there are going to be more children to be educated. There will be more delinquents; there will be a need for more prison space, and more and more people who need dental and health care. One should attempt to create a monopolistic position, in the sense that you have an agency which can deliver, and that this is a set of services absolutely essential to the successful performance of all other services. In this context, until you fund rehabilitation, you can't fund anything else if you are going to serve your client groups. Because, what is being asserted, basically, is that, until one has an integrated, coordinated service system at the local level in terms of the individual client and his needs, funding specific programs is ineffective. Thus, the first step is to establish a large and effective rehabilitation system which will integrate all other systems. In the long run, it may very well be that rehabilitation will not be given this particular role; but if it is not, something similar will ultimately emerge because the need does exist, both in terms of serving the client and getting the greatest return for the public dollar invested. There is no point in re-inventing the wheel, all the time.

From a political and marketing point of view, a certain point should be emphasized. In terms of the counselor representing the client through the system, it will reduce the demand of the client group to take over the system in order to assure that it serves the intended end. There seems to be little question that the thrust of the Negro community, in terms of their demands for greater decision-making authority over community agencies, results from the failure of the agencies to adjust to their particular needs. If the Negro community were to have some assurance that there existed effective professional, technical representation in processing Negro children, for example, through the schools, perhaps the demand for control might possibly be alleviated. This is something which would be quite pleasing and acceptable to the existing white political establishment.

In this context, we can view the counselor as a type of "ombudsman" who works with the red tape and the mazes of bureaucratic agencies. He investigates the grievances of the client. He assures proper treatment through the agency. The dilemma which the legislator and top official face is the inability, at the individual level, to assure a responsiveness on the part of the agencies. Another aspect, in terms of marketing, is to change some of the terms. The term "counselor" really does not reflect what we are talking about; nor does the term "rehabilitation system" adequately describe its function. Rehabilitation counselors should be called "service coordinators" ... Community Service Coordinators. For the rehabilitation system, one might use the term, Community Coordinating and Delivery Service System.

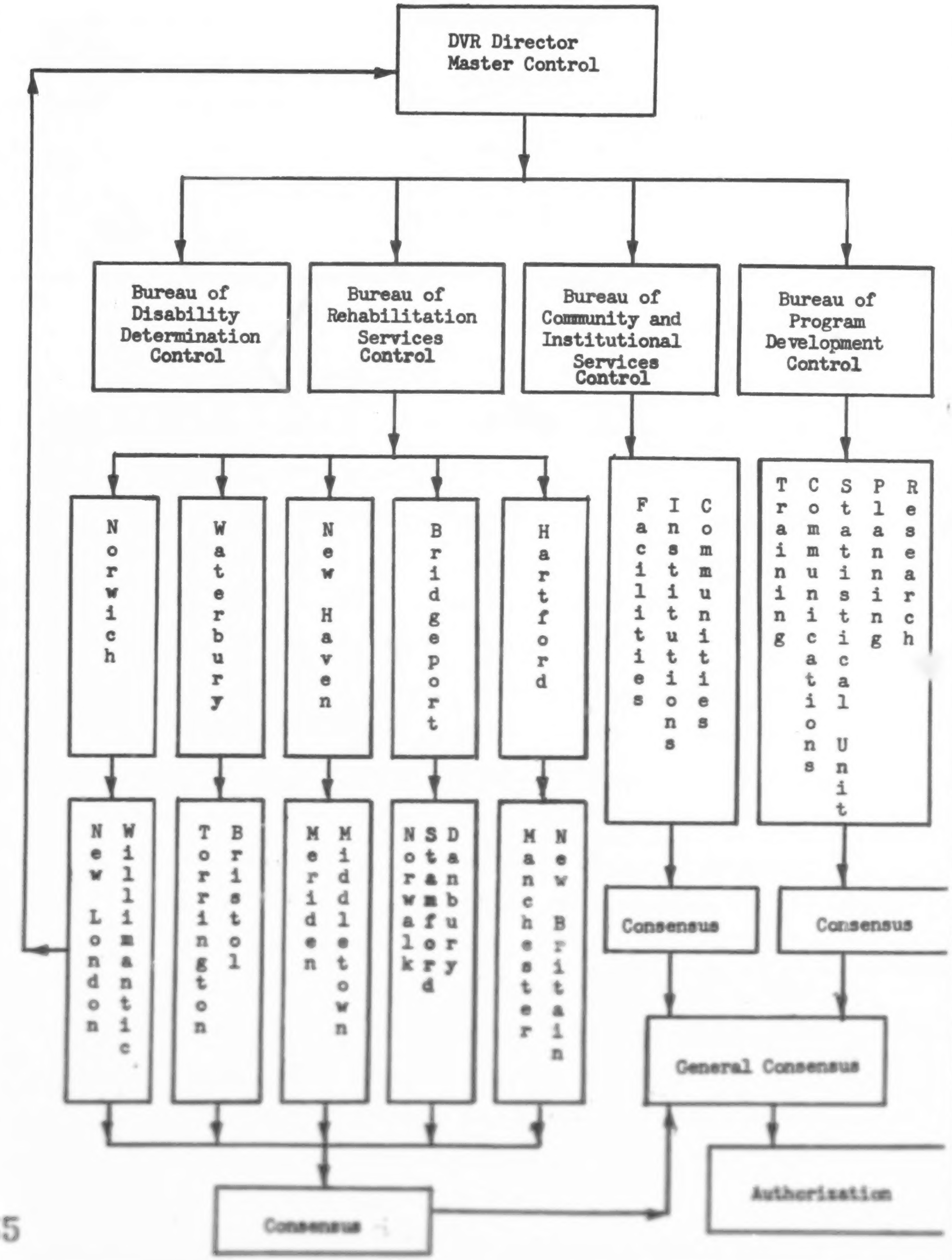
MANAGEMENT SYSTEMS

The following discussion of the management system rests on my text, Management: A Systems Analysis .

I will assume, for purposes of discussion, certain knowledge as to the nature of management systems. Let me emphasize, once again, that what we are developing is a plan or a paper system. Many of the points and arguments may not, at this time, be feasible, acceptable, or saleable, but these questions can be taken up later. To sell a plan is to attempt to sell a set of mental ideas. Prior to such a selling effort, one has to develop such a set of ideas. At the point of developing a sales presentation itself, one can pick and choose among the ideas and delete those which, in terms of the client, may not be saleable at a certain point in time. As with the previous analysis, there is an attempt to develop those aspects of the rehabilitation system which would be most attractive to a potential buyer. There is one point which I forgot to mention in the prior analysis, in terms of program development. Ideally, as one moves to integrate a community service system, there is recognition on the part of the community agencies that more effective integration and coordination are necessary, which means that they are willing to accept a kind of client logistic system or a client material handling system, which the rehabilitation agency will provide. In terms of budgeting, either the agency will sub-contract this function to the rehabili-

CHART III

MANAGEMENT SYSTEM (INTERNAL)


DVR Director
Master Control
Bureau of Disability Determination Control
Bureau of Rehabilitation Services Control
Bureau of Community and Institutional Services Control
Bureau of Program Development Control
Norwich
Waterbury
New Haven
Bridgeport
Hartford
Facilities
Institutions
Communities
Training
Communications
Statistical Unit
Planning
Research
New London
Willimantic
Torrington
Bristol
Meriden
Middletown
Norwalk
Stamford
Danbury
Manchester
New Britain
Consensus
Consensus
General Consensus
Authorization
Consensus

tation agency in terms of a transfer of funds, or else the legislature, recognizing the need, will allocate sufficient funds to provide this capability. Such an allocation can be viewed from two points of view.

Insofar as the rehabilitation logistics system services other agencies, it can be viewed as funds necessary to facilitate the operation of such agencies and, in this sense, could be costed to such agency operation. As, for example, if a mental institution is to remain a viable agency, it is not only essential that it provide treatment, but that the treatment be integrated into the community need for placing a patient on the job. One may cost this to the hospital itself. Some manifestation of this, of course, is the outpatient treatment process, or halfway house. It is inefficient for every community agency to have its own integrating devices into a more total community, for a variety of reasons; one of which is that, at best, it is only a partial solution. The other is a clear recognition on the part of the legislature that such service should be funded directly. Returning to management system, we might first look at Chart III, Management System - Internal. This chart represents the current rehabilitation structure from a management system point of view. This is done in terms of function or activity. The management system is viewed as essentially the problem-solving or program-developing system.

Suppose we have a problem input into master control which would be, presumably, the Division Director's level. At this point, problems would be evaluated in terms of that part of the management system geared to handle them, and sent to that part. One unit with which we are particularly concerned is Program Development. Second is the Bureau of Community and Institutional Services, in which one finds the certification of rehabilitation facilities and approval of workshops. Finally, the largest unit, the Bureau of Rehabilitation Services, is the third sub-control unit. The problem is then processed to any of the sub-units within these, in terms of either developing a program or correcting the problem, whatever it may be. I am not going to get into any detailed analysis of program development. The essential thrust of this chart is to get at the consensus step. In a very broad sense, the rehabilitation service, with its sub-units in Hartford, Bridgeport, New Haven, Waterbury, and Norwich, constitutes the operating segment of the agency, whereas Program Development and Community Institutional Services represent largely staff functions. Thus, from a program development point of view, one would normally visualize the flow of problems originating in master control if these problems are essentially program content problems, as distinguished from what we might call implementation, or day-to-day administrative problems. Program problems will go either to Program Development or Community Institutional Service, depending upon what the problem is. It might be training, it might be statistics, it might be re-design of the management system or research into the management system; it might deal with the technology of rehabilitation, as found in community and institutional services, or evaluation of rehabilitation facilities, etc. Such programs would flow into the rehabilitation service. However, to effectuate the flow, a consensus has to be reached between the staff planning unit and the rehabilitation program service. We do not get into the mechanics of reaching a consensus, as these are fully explored in the text noted above, except to note that a consensus would involve administrative heads dealing regularly with program suggestions and reaching agreement on these. The extent to which you may want to involve individuals in the consensus can reach down to the counselor level, and there is no serious difficulty in establishing the appropriate paper flow, even if this extends over geographical areas, as it does in this case. Assuming a consensus can be reached, the program is then authorized and implemented. I would assume that, since we are looking at the internal management system of a rehabilitation agency, we are concerned entirely with programs which fall within the authority of the agency head to authorize.

What this chart is responding to is, essentially, the problem of how to achieve an intra-agency cooperation and, particularly, cooperation on the part of the basic component of this system, the counselor. What is being suggested in terms of administrative processes is the essential requirement of setting up a consensus, or agreement making mechanism, in the program-development or decision-making processes. From the counselors' point of view, I see no reason why they should respond favorably to programs developed by staff units in Hartford, which are unilaterally imposed on them, which they may neither understand nor see the need for, and which place burdens upon them. A consensus, or agreement, has to be reached which reflects the interests and realistic operating context of all units, and which will, in fact, serve the interests of these units. These problems are resolved at the consensus step. We may take the example of developing statistical reports. If there had existed a full-fledged consensus mechanism when the statistical report program was developed, it would have cleared through these to the counselor so that the designer could have received feedback as to the problems encountered in the field of utilizing those of particular value, -- perhaps re-design, etc. Moreover, at the consensus step there is simply the technical aspect of coming to understand programs; but the programs are more acceptable if they are always in the suggestive or formative stage. Please notice that it is not until agreement is reached that a program is authorized. This means that the counselor will not be burdened with programs to which he has not, ultimately agreed. It is the agreement which effectuates the cooperation within the agency. Counselors should have the opportunity to raise problems which should be channeled into any one of the three sub-control units. This opportunity constitutes both a check and a feedback to the initial design work, or programs developed, insofar as the counselor is concerned. The essential element is to create a feeling, on the part of the counselor, that he is involved, continuously and actively, in program development; and there is no reason why the counselor cannot participate both through the consensus and the problem raising steps. Control units have to work in a fashion which enables us to get an effective feedback and response from counselors. Once the principle of control units -- consensus- problem raising-feedback -- is established, the actual mechanics of setting up the operation can be gone into.

NETWORK MANAGEMENT

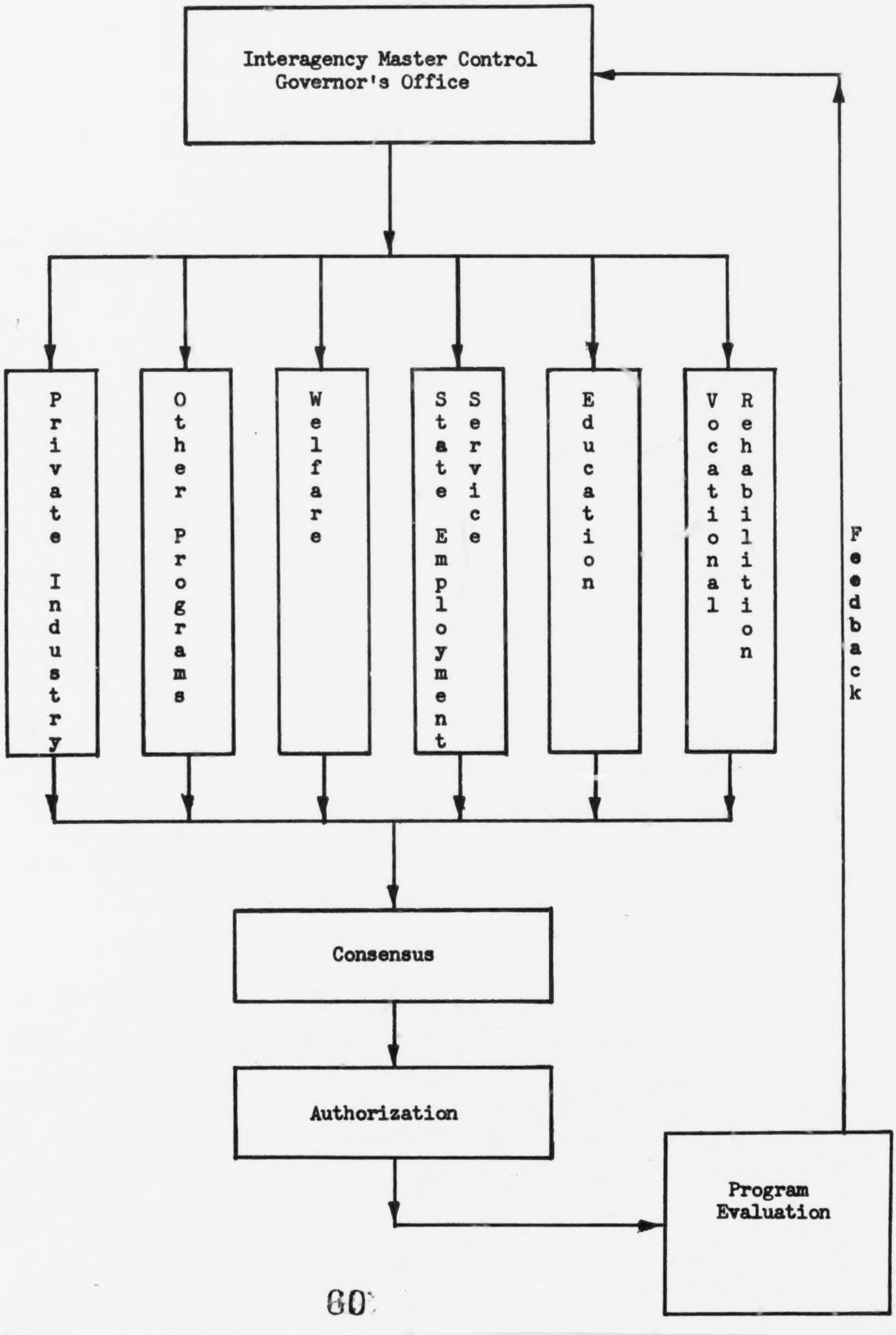
We might look, now, at Network Management, Chart IV and consider, as well, the general proposition of devising integrated, managerial programs among agencies at the local or State level. We might recall, in the discussion of the system, when we viewed the counselor as an integrator on the individual level, that the problem of how to integrate agency services, one with the other, was not taken up at that particular time. If we view the rehabilitation system as the material handling and integrating unit for a multi-agency community system, one problem is how to get the other agencies to accept this particular role* assuming you have outreach capabilities to potential client population. Also, from the rehabilitation point of view, how do you encourage agencies to ad-

---

* i.e., a coordinating rehabilitative role

CHART IV

NETWORK MANAGEMENT (EXTERNAL)


Interagency Master Control
Governor's Office
Private Industry
Other Programs
Welfare
State Employment Service
Education
Vocational Rehabilition
Feedback
Consensus
Authorization
Program Evaluation

just their programs to clients' needs? In other words, ultimately the solution to the effectiveness of rehabilitation rests with the diagnostic and treatment agencies, and not with rehabilitation. Rehabilitation can raise problems as to the appropriateness of treatments that have occurred. We might look at this problem more closely and think in terms of diagnostic and treatment effectiveness on the part of other agencies, as viewed from the counselor's point of view. Here we are looking at the counselor from the ideal point of view, as a representative of the client, who matches diagnosis and treatment, and who acts as integrator of services. Looking back at Chart I , Model Client Service System, there is a continual feedback to the counselor as to the client's result in progress. Now it can be assumed, in some instances, for a variety of reasons, either from the client's point of view, or from the counselor's point of view, that either the diagnosis or treatment is inappropriate, and problems are then raised. The question now becomes, how do you get the agency to adjust to client needs? Chart IV, Network Management, suggests that one has to create, not only an intra-agency management system, but an inter-agency management system. And briefly, we might go through this mechanism from the point of view of Vocational Rehabilitation. Let us assume that there is an inter-agency committee which can be established, consisting of representatives on the local level, from the following agencies: Rehabilitation, Education, State Employment, OEO, Model Cities, hospitals, private industry, correction institutions, and many others, of course, both private and public. This committee, with appropriate staff assistance, would be considered a master control unit for all the committees. Let us now assume that this is operational and that certain problems arise, from the counselor and client point of view. Depending upon problem definition and what problems are presumably acceptable to all the other agencies, the counselor would raise a problem which would be sent to the Inter-Agency Master Control Committee, which, in turn, would send the problem to the appropriate unit for solution. This might be, for example, OEO. OEO, in turn, would develop the appropriate response and the problem would then go to the consensus, except that we now enter the inter-agency consensus mechanism. The consensus mechanism could be the same inter-agency committee, consisting of representatives from all the agencies. If a consensus is reached among all or a majority of the agencies, then each agency would authorize the program, and it would be implemented within the respective agency. Subsequently, the program would be evaluated, presumably by the agency itself, and if the problem were not corrected, it would feedback and rotate again through the management network. Notice what is being suggested by way of an integrated effort. At one level, the client level, the initial analysis emphasized the role of Rehabilitation in terms of providing a coordinated integrated community service for the client. That is, we are attempting to integrate effort around clients' needs. Another level, which would be the management level, or programing level, also requires an integrated management approach in order to be effective. This is called Network Management, where there is a cooperative undertaking to assure that programs developed within the agencies are nutually consistent with each other. Aside from internal programs that are worked out within Rehabilitation itself, the essential role of Rehabilitation, in terms of management, is one of problem raising and program evaluation, as far as other agencies are concerned. Both at the client's level and at the aggregate program evaluation level, Vocational Rehabilitation is the only agency continually collecting data as to other agencies' effectiveness. We can think of agencies' effectiveness in either of two senses: in terms of the agency and in terms of the client. It is the latter with which we are concerned, from the rehabilitation point of view. From the agency point of view, each agency, with its unique service and tecnnology, has its own measurements of effectiveness. Thus, in the education institution, we would view program effectiveness as the extent to which the children have learned a certain amount of history or science or math or reading skills in a certain period of time. However, the school is not concerned with the psychological health or social skills, or communications skills, or vocational skills, or economic condition of the student or his family. These matters are picked up by other agencies in the community. Agency effectiveness is measured in terms of what agencies stipulate that they are going to do. However, from the rehabilitation point of view, we are looking at effectiveness, not in terms of agency programs, but rather in terms of the long and complete development of the individual client. Thus, we are going to measure agency effectiveness in terms of client progress and response to agency effort. Conversely, the teaching of history may be completely irrelevant, in terms of developing the communication skills of the child, as to his eventual effectiveness in the community, or on the job.

This is the old "bromide" that, from an agency point of view, no one is interested in the total individual. With the new mandate which Rehabilitation has received, the possibility now exists that rehabilitation should be concerned with the total individual. Agencies have emerged to provide a set of specialized and restricted services which will be of assistance to the client only in one dimension. Thus the educational system is concerned with his educational development, but with no other aspect of his development. Model Cities might put a good deal of stress on housing, but not on education. Correctional institutions, although it is difficult to say with what they are concerned, are presumably concerned that the criminal be less prone to commit crimes. State Employment is interested in placement of the client, but not with his psychological health. It is becoming increasingly apparent that one really cannot think in terms of educational program effectiveness without considering other agencies and programs, because eventually one must get back to the client. This does not mean that a local community must have some type of comprehensive single agency delivery system, because this is quite impossible and would, of course, be unmanageable. It does mean, however, in terms of program development, that agencies ought to be aware of the client and of the programs of other agencies so that they will have mutual support and be integrated rather than dysfunctional and non-productive. A hungry child cannot learn. Vocational Rehabilitation has a particular responsibility here because it is in the unique position of being able to review program dysfunction and the absence of program integration. So just as Vocational Rehabilitation can act as the integrating unit, as far as the client is concerned, it can, from an evaluative point of view, act partially in the same manner as far as programing is concerned, if one has an inter-agency master control unit. Even in the absence of an inter-agency control unit, it is hoped that the counselor and agency would be effective in a diplomatic way, so that they could raise problems for the treatment and diagnostic agencies, to make them more responsive to client needs. In that sense, Rehabilitation could act as a master control unit for other agencies. It should be suggested, in the chart of Network Management, that agencies may cooperate on a completely voluntary basis. That is, the inter-agency committee, the master control unit, could be a group of representatives who voluntarily get together; voluntary authorization is restricted to each agency; feedback would be of mutual interest to see how well programs are working. Notice, by way of management design, that no reorganization is being suggested; there is no suggestion to modify agency authority; there is no threat to traditional managerial status; there is no suggestion of agency competition. Vocational Rehabilitation is not suggesting that it should perform an educational or placement role; these should be kept as they are. As a matter of fact, Vocational Rehabilitation is providing a service to the other agencies in making them viable and effective, as they have no follow-up themselves and frequently are not informed as to the ultimate effects of their programs.

The critical aspect is how to get a consensus between agencies, and here consensus always works on the basis of finding a program which is advantageous to more agencies. Vocational Rehabilitation will not be able to force other autonomous agencies to change. Therefore, we must search for programs at the consensus stage which are mutually beneficial to various kinds of agencies. Also, there might be negative incentive, as, if the agencies do not voluntarily cooperate, they will be forced to cooperate by higher authority at the State or Federal level. The other alternative, -- a competitive service system in the form of OEO and Model Cities, -- might be established which would work with Vocational Rehabilitation and be more effective.

Running through this report should be orientation to the idea that what is being presented is the role of Vocational Rehabilitation in the community, both at the client service level and at the management network level. In other words, this approach can be presented to others, descriptive of Rehabilitation from a system point of view, by taking a descriptive point of view, showing what the agency is, what it does, where its place is in the community at the client-management level. Suggestions are being made as to any changes which will make presentation more accep-

CHART V

NETWORK MANAGEMENT SYSTEM DESIGN

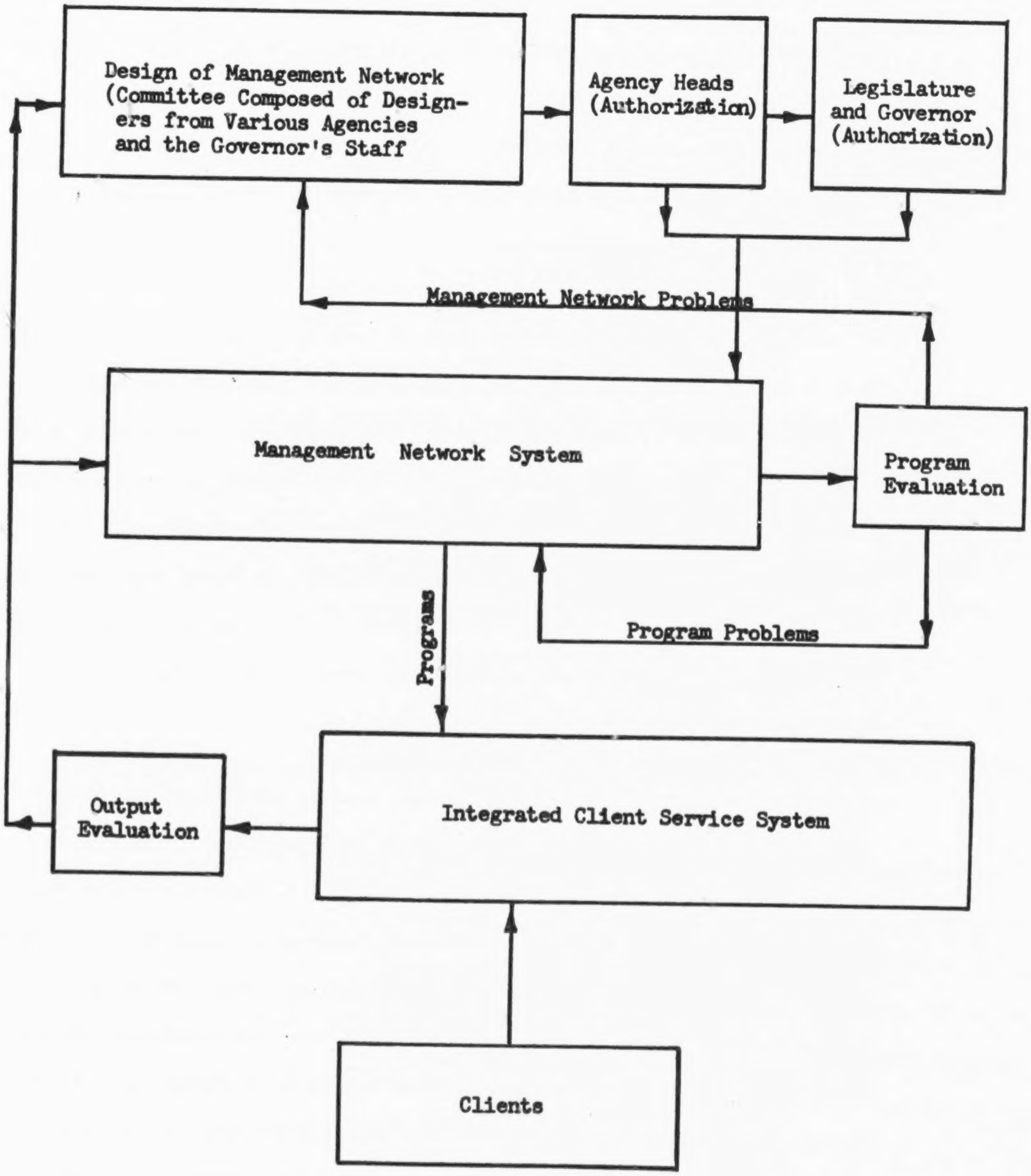
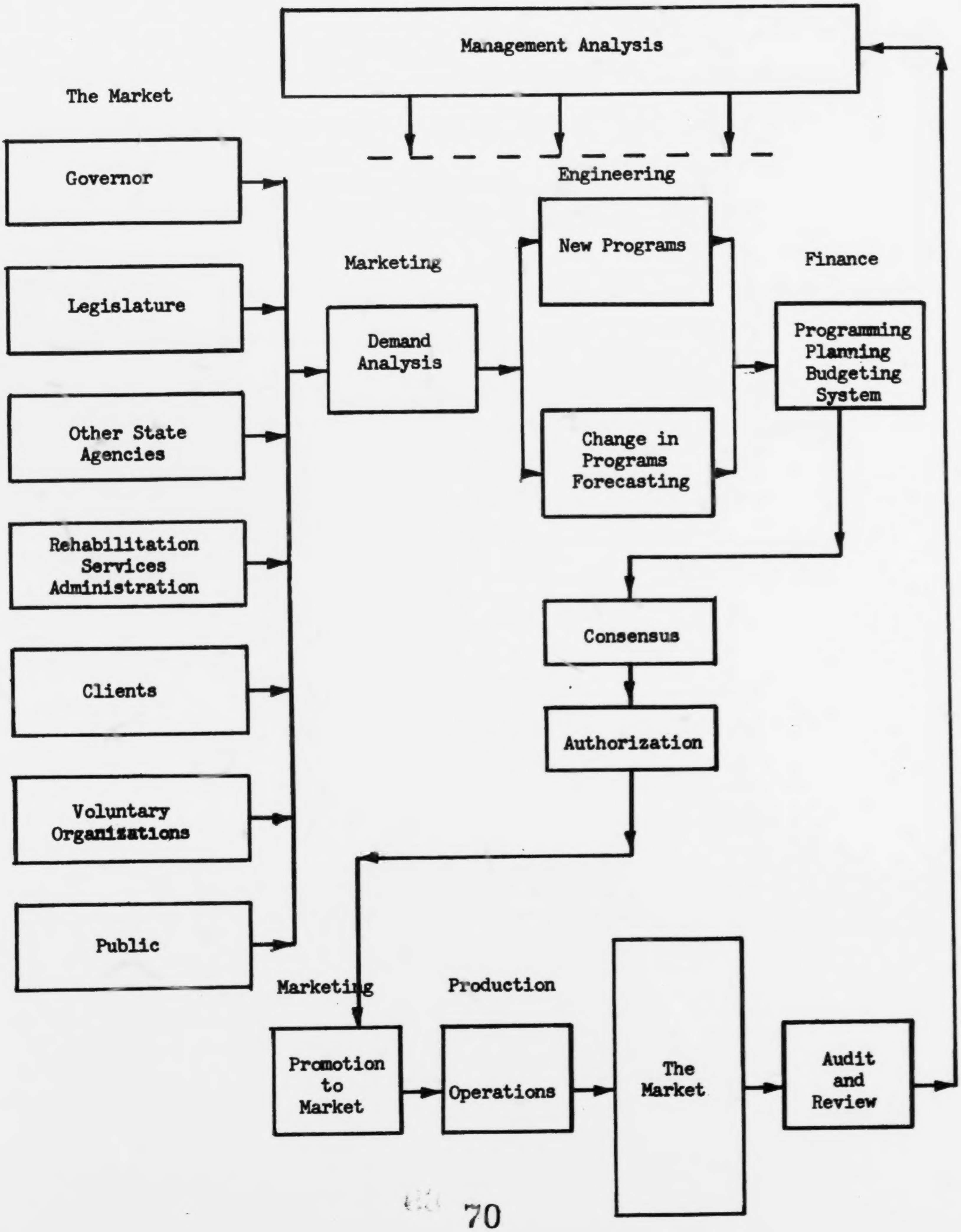

Design of Management Network (Committee Composed of Designers from Various Agencies and the Governor's Staff
Agency Heads (Authorization)
Legislature and Governor (Authorization)
Management Network Problems
Management Network System
Program Evaluation
Program Problems
Programs
Output Evaluation
Integrated Client Service System
Clients

table. In other words, when we look at Network Management, we can say network management is currently working. Counselors are working with other agencies' problems. Presumably, other agencies are developing new programs to cope with the kinds of observations which the counselors are making, if they are doing their jobs. Presumably, also, the counselors are picking up this information in terms of the actual progress that clients are making, or from what they are hearing from the clients, themselves. So, in a sense, one could say that Vocational Rehabilitation is involved in a kind of network management and is attempting to reach a consensus with other agencies, which is true in terms of approving workshop facilities. A kind of evaluation does take place by the counselor which is fed back to the other agency. The reason for emphasizing this point is that, in utilizing the material in the report, one may say that the report asks, "What is rehabilitation at the client and community level?" and no one is then frightened by the changes being proposed. One can then go on and say, "Well, we might try to improve the existing system, but we don't really see any need for drastic changes which are actually not feasible."

What we are trying to do is present a clear picture of the unique role of Rehabilitation which will support an expanded program. If the buyers accept this approach, one would get into a drastic revision where Rehabilitation would take a very unusual, important community role. Chart V we might consider as a Network Management System Design, which is not really germane to the report, but which completes this analysis, Network Management, and relates to the design of the Network Management System itself. By way of a more generalized thrust, we are dealing with the central problems of integration and coordination, and we can, from a normative point of view, suggest that integration and coordination will be desirable in terms of potential client group. There should be, at the agency head level (which will really be below the Governor level), an ad hoc committee which would be concerned with the design of a Network Management system. This will be a professional staff, in part, but there also will be representatives from other agencies. These representatives would also be professional staff designers who would be familiar with doing network analysis and design. Notice that, at the lowest level, we have the client going through the operating system which gives one an output; this output will, in turn, be evaluated, and if it is not up to program expectation, a problem will have been raised, and such problems will feed back into the management system which we discussed in the previous chart. The question which has now been raised is, "What happens if the management network system doesn't work as it is supposed to work; that is, if you don't get the kinds of consensus, problem raising, or problem flow-through desired?" One needs a higher capability to re-design the management network system. This is of concern in this particular chart. Presumably, such an agency or network system staff assistance, would develop a management network procedure which could be fed to agencies' heads for consensus and authorization, and to the legislature or the Governor for authorization, and then fed back into the management network system to get more effective programs. This third system, the Network Management Design System, would not be concerned with actual program content. Rather, it would be concerned with the problem of how agencies go about solving their mutual problems, on one hand, and would, on the other, look at the manner in which its administration is carried on and define administrative shortcomings. In other words, Network Systems Design relates to the design of the management system where, at a second level, the management network system, itself, relates to devising operating programs for the client. Now, what is the special responsibility of the rehabilitation agency at the network design level, or the third level? It would seem that the responsibility remains essentially the **same**. We have an agency which is particularly concerned with an integrated program approach, and because that is its unique responsibility, it should be actively involved with the development of the Network Management Design System in order to cope with the interface problems. Future program development of the rehabilitation agency should not only consider planning its program within its own agency, but also planning to work out cooperative relationships with other agencies. Therefore, it has two dimensions, 1) the relationship within the agency, and 2) the inter-agency relationship. As we go through this report, we start at the lowest level in terms of the relationship between counselor and client. We move on to the relationship between Rehabilitation adminstrators and counselor. That was taken up under Management Systems. Now when we talk about Network Management Design, we are talking about inter-agency relationships. All these relationships, presumably, should be taken into consideration in terms of the long-run planning effort. It may well be, as the planning effort develops, the possibility of developing systematic inter-agency planning, or systematic, inter-bureau planning within the agency, is fairly far-fetched. However, from a planning point of view, at least, a problem can be raised, in terms of the boundary of planning effort; one can make the allegation in talking about "what are we going to plan". There is a set of relationships with which the agency should be concerned and, in a very general way, this is the set. How one would go about implementing a plan, or what the plan itself should be, is really another question; but in the planning effort, the boundaries should not be overly restricted, at this point.

CHART VI

FUNCTIONAL ANALYSIS


Management Analysis
The Market
Governor
Legislature
Other State Agencies
Rehabilitation Services Administration
Clients
Voluntary Organizations
Public
Marketing
Demand Analysis
Engineering
New Programs
Change in Programs Forecasting
Finance
Programming Planning Budgeting System
Consensus
Authorization
Marketing
Production
Promotion to Market
Operations
The Market
Audit and Review

REHABILITATION - A FUNCTIONAL ANALYSIS

Vocational Rehabilitation can be approached from a variety of points of view, and there are various analogues which can be used to develop a certain type of perspective. At least two have been used: 1) the physician-patient relationship; and 2) a general systems approach. Another analogue can be a functional analysis in terms of business organization, in terms of planning certain kinds of capabilities within the agencies, and analyzing present agencies' operations and capabilities. The rehabilitation function as shown in Chart VI will be designated from a business point of view.

We might ask, What is the production function of Rehabilitation? Or what, specifically, is it that Rehabilitation does? One may say that Rehabilitation is in the business of network operation, or it is in the client-material-handling business. The marketing function of Vocational Rehabilitation really relates to one dimension of program development. That is, we don't have a marketing function in public institutions and agencies, or non-profit institutions. We call it a "program development function". It is this unit which is particularly active in deciding what new services should be offered to the market which the agency happens to serve. A new program would be a new set of services; and, if we think of marketing as being particularly concerned with the development of new products, or with improving the existing products so as to satisfy the customers or clients, it would appear to be essential that Rehabilitation have a permanent program unit or capability. This is not research and development which, as we shall see subsequently, relates to what we will call the "engineering function". The significant question to be asked is: Should program development be on a permanent basis? The answer is self-evident. It is the same as the answer to the question: Should a business organization have a marketing function? If the business organization did not have a marketing function, it would not be in business. It is absolutely essential that a State agency have a marketing capability, and this marketing capability should be a permanent function.

A marketing or program development function performs three functions:

1. It carries out demand analysis.
2. It suggests a need for new programs.
3. It "sells" existing programs.

Now let us look at each of these functions. "Demand analysis" is a matter of determining what the nature of the market is. There is also the matter of determining specific needs in the market which the rehabilitation agency will satisfy, and determining which program, or particular set of services, is going to be supplied to satisfy a particular client group. This is in terms of a unique rehabilitation production function. The first questions raised are: Who is the customer? Who is the market? What is the population of the market? Here one designates the legislators and Governor, the political market which provides the funds, and other agencies which may, potentially, provide funds to Rehabilitation on a sub-contracted basis. The other aspect of the market is, Who is the client whom we are going to work on? This is, of course, the individual who is going to be rehabilitated. Who is in that group? Once the population is designated, then one has to ascertain the particular needs of this population. What, specifically, do the legislators and the Governor want, by way of service, from the agency? Given this very restricted customers' group, it would be particularly important to know exactly what each legislator wants from Rehabilitation, and what his perception of Rehabilitation is. Insofar as Rehabilitation is in the Education Department, the Education Department, at the higher administration level, constitutes the outside environment of the rehabilitation agency. It would be important to know what the Supervisors and Commissioners of the State Education Department want from rehabilitation. These are prime customers. Also, what is the customer's ability to pay? One has to estimate a reasonable, sophisticated, and realistic evaluation as to the monetary potential demand over some set of years, for the service. And here, it seems to me, the agencies make serious mistakes in their forecasts. Obviously, one can postulate a very large client demand for the services, except that the difficulty is that the client is not paying for this service. The legislature is paying for this service, so they will determine how much service will be rendered. We can use the same kind of analysis as industry does. One can easily start off with a marketing analysis and raise the question as to how many people are in need of, or can use automobiles. One might come up with something like a hundred million cars yearly. However, car manufacturers know they are not going to sell a hundred million cars, because all those who may need a car are not now in a position of being able to pay for the car. The actual market is made up of those who both need and are able to pay for the cars. Now, the fact that those who receive the service, and those who pay for the service happen to be two different groups, does not really change the analysis insofar as estimating the potential demand for the services is concerned. Potential demand is being analyzed in terms of the likely budget, or how much money the legislature will allocate to the agency over a period of time. This is the "ability to pay". This does not negate the necessity of ascertaining potential clients who will need service, and the particular kind of service they will need, because, at the operating level, from a production point of view, you will still have to deliver services. This simply makes the marketing analysis, or demand analysis, somewhat more complicated, in that you will have to look at two different and distinct markets, due to the fact that the person who pays for the service is not the person who receives the service. As far as potential marketing is concerned, over the next five years, some clear, realistic estimate has to be made as to the kind of funds which the legislators, both at the Federal and State levels, will allocate because this gives you your operating budget. At the client level, one has to do certain kinds of screening, outreach, advising, etc., to be assured that one will get the client whom one is set up to service. However, it does appear that we will have many more clients to service than there is money available to take care of. The legislators' market is the basic constraint and is the critical market which has to be "sold". We will get to the selling function later. Assuming that the legislators represent constituents and have some idea of the needs of the constituency, they should have some idea of the kind of programs which they would like to see implemented. This kind of market research data, in terms of what the customers want, suggests new program content which the program development function would pick up and develop, insofar as one has the engineering function within Vocational Rehabilitation. One also has to do an analysis of the nature of the competition. Rehabilitation is not the only agency which will be competing for State funds. What is the competition doing which you are not doing, which you can do better in terms of producing certain programs, as far as the legislators are concerned? This might be a lobbying kind of activity.

From a business or a marketing point of view, the function of the

Statewide Planning Project for Rehabilitation Services, as far as its relationship to the agency is concerned, is to make a market forecast for the next five years. It is doing a market research function for a State agency, and the plan that we are supposed to come up with is a forecast so that other functions of the agency can begin to gear up to meet that particular forecast. This is really no different from the marketing research, or demand analysis, done in industry in which the marketing division prepares five-year forecasts of the demands for new products. So, while we are calling ourselves a Statewide Planning Project for Vocational Rehabilitation services, what we are really trying to do is market research, the end product being a market forecast. To a large extent, the work really relates to the demand for the services of the agencies over a five-year period. The analysis, in a sense, has been restricted to the client market segment, i.e., how many people will require rehabilitation, when they will require it, and what type they will require. The budgeting side of it, or how much money will be available for the particular kind of program which the legislators and the Governor and other agencies are interested in has not been, perhaps, quite developed. What is important, here, is that this has to be viewed as a continuing function. One cannot make a forecast every five years, and stop, on the assumption that the agency will then be able to work with that forecast for five years. Forecasts must be constantly re-evaluated as to their accuracy, particularly a forecast which will be used in an operational context because other functions are gearing up to meet that particular forecast, which must be constantly changed. This means market research, forecasting, demand analysis, need analysis; finding out what customers want is a continuing kind of job to assure that the agency is adaptive to its environment and is not providing costly services which individuals cannot or will not use. Thus, whoever has to make the decision as to whether or not program development is to become a permanent function, has to be convinced of the essential nature of the marketing activity in a State agency. In the actual selling of program development, one can describe why certain activities have to be carried out continually if an organization is to remain adaptive and viable in terms of its environment and always able to serve its clients' needs. It may well be, since marketing has various functions, that this is one area which has to be effectively staffed and built up.

FINANCIAL FORECAST

In terms of doing a demand analysis, we might look more closely at the result of such an analysis, at least in economic terms. This will be the financial forecast of the agency's budget in the next five years. At the outset, one might estimate three possible budget figures: 1) optimistic, 2) realistic, 3) pessimistic. Let us consider the optimstic budget for the next five years, which will be that budget the agency would like to receive in terms of its estimate client potential or caseload over that period of time. Presumably. it is the Harbridge study forecast, as found in its report of 1965-1966. We have here the forecast of an annual budget of some $7.2 million, by 1971, with 6,000 cases a year and a field staff of 120. The source of funds would be $1.8 million from State, and $5 million from Federal financing. It is assumed that the purpose of formulating this particular budget is largely for marketing purposes, or to sell the Department of Education and the Legislature on the need for a $7.2 million budget for 1972, if the potential client group which will need the rehabilitation services is to be served.

One must know, in making financial estimates, the purpose of the estimates. Is one making the estimates to convince the buyer that one should receive "this much money", or does this constitute a realistic forecast? Do the administrators of the agency, in fact, really believe that they will receive $7.2 million in 1972, and are they, in fact, planning the future operation on that basis? There can be two reasons for our forecast. One reason is getting the money. The other is to regard the forecast as a planning tool to delineate the scope of the program one is gearing up for. We are using this forecast as a planning tool. This is really the second forecast, a realistic forecast which might be used only for inter-agency purposes and held confidential in a restricted group of individuals who have the planning and responsibility for what will occur in the area of budget growth, between 1967 and 1972.

Finally, the pessimistic budget will be one which postulates a series of unfortunate events occurring, auch as estimates of Federal contributions proving unwarranted. The reason for making the pessimistic budget is to allow planning the operation to cope with the eventuality. Three forecasts, therefore, result in three sets of plans. One will develop a set of plans on the basis of an optimistic forecast which assumes that $7.2 million will be received by 1971, and seek to determine the capability the rehabilitation system in terms of counselors, locations, and caseload required. If one takes a more realistic view, one will have another plan. Finally, if one takes a pessimistic view, which is that the Federal contribution for the next five years will be on a percentage basis, and will be less than during the last five years, then what kind of plan does one need for this particular forecast?

What particular methodology does one use in terms of estimating these three forecasts? One might use a simple trendline which, of course, has been used. One may, on the basis of data continually picked up at the legislative level, talk to the staff around the Governor concerning the emergence of particular public policies, agency competition, etc., to make a judgment as to what the growth in funds will be. This is largely a matter of going behind the figures and discovering why particular allocations occur over a period of time. This is a matter of growth in economy, the raising of State taxes, the development of particular public policies, the growth of other agencies, political events in terms of which parties are elected, etc. Private companies have developed a very sophisticated market forecast which derives largely from government allocation in the defense sector. I am not suggesting something like this, but I am suggesting consideration of some of the factors, on a continuing basis, which might go into making a realistic forecast in terms of client need. Client need is only one data input as to what the budget will ultimately be. The significant data input, however, is not what clients will need, but what legislators will allocate. Of course, forecasting is a continuing activity and function. One can usually think of it as a rolling five-year plan, in which one continues to add on the additional year, and five years in the future passes through the current year. One will have a five-year plan for 1966-1971, from 1967 to 1972.

One can evaluate the forecast from two points of view, marketing and planning. From a marketing point of view, the evaluation of the forecast is in terms of the agency's success in selling it to the legislators; and the strategy here is to select a forecast which, although high, is not so high that it will be significantly reduced by the legislators, or would appear irresponsible. In this context, the budget forecast is part of the agency's overall marketing strategy. The realistic forecast turns on the question of whether it is, in fact, correct or not. That is, if one has forecast $7.2 million by 1972, with an annual growth rate of 20 percent per year, one can evaluate such a forecast in terms of whether this has, in fact, occurred. One can calculate a statistical distribution around the forecast to arrive at errors in forecast. The purpose of the realistic forecast is planning. New districts may have to be established, new counselors hired and trained, etc. The value of the forecast here is in terms of "lead time". Assuming that the forecast is reliable, one can begin selection and training, renting office space, and setting up programs prior to the actual operation, assuming that the funds will be available when the facilities come onstream. The extent of the forecast depends on how much lead time one requires to set up expansion in one's program. If it takes two or more years to train a counselor, one has to decide, this year, how many counselors will be required three years from now. In order to make this decision, one has to have a realistic forecast of what the budget will be three years from now. There is no magic, or fixed necessity relating to a five-year forecast. Five years is an arbitrary figure. Actually, what one wants is a forecast in terms of the amount of lead time which is necessary to build certain capabilities. It may be necessary to set up curricula at universities which will eventually train counselors, and this may require a 10-year lead time. Under these conditions, one might want a ten-year forecast as to the number of counselors which will be required in 1978. Obviously, the further into the future one projects, the greater the risk involved that one forecast will be incorrect. However, because of fixed lead time, someone has to assume risks, and the purpose of making realistic forecasts is to reduce the risk. The alternative is to receive allocations of funds and be unable to use them effectively because the agency is not geared up in terms of personnel, locations, etc.

It would seem that this is another argument for having a permanent "Program Development Bureau". Assuming that this Bureau will be constantly working with the forecast and estimating future budget allocation as part of its planning, it will be submitting estimates as to personnel and location needs in the future. Assuming, also, that this kind of planning is detailed and takes regular time, and is continual, it will mean that the Bureau of Program Planning will be working with the segments of the agencies responsible for gearing up future expansion. In other words, the Bureau of Program Development will be working with the bureau which takes care of training, the bureau which rents facilities, etc. One could not reasonably expect, at this time, to formulate a plan for five years and do no additional planning for another five years, on the assumption that training in manpower faciltities, certification facilities, and vocational analysis will automatically go on in the absence of any future corrections as to a forecast on types of clients, or the nature and import of the market and agency. A marketing function which would lead to greater agency success, both from the legislative and client's point of view, would relate the data to be picked up from the legislators and clients by the marketing or development bureau to possible new programs which could be developed to satisfy these particular needs. Also, data would be picked up as to some of the difficulties, in terms of existing programs, and changes to be made in these so as to provide more effective service. You might look at this from the legislator's point of view. Ideally, I would like to assume that one had a capability within the agency to be picking up information, continually, from the Governor, staff, and legislators. This might be a matter of making the rounds and talking to the personal staff or secretaries of legislators, as to the kind of data they are receiving on the rehabilitation program, from their constituencies, and as to how the program might be expanded or changed to take care of problems which the constituency may have and which Rehabilitation either is not currently taking care of or could possibly take care of if new programs were developed. Another source of data would be the personal preferences of the legislators. I am not certain how such a mechanism would work in terms of having staff available to pick up this information and deal with the market. This is a market research activity. Obviously, one would not call these individuals market researchers. They might be called "program evaluators", and in terms of program evaluation, they might simply be checking out the responses of those who are buying the programs. The other source of need-analysis which would generate new programs is, of course, the clients themselves. The counselors are picking up this data which would go to a unit called the "engineering unit", designed to formulate new programs. We shall subsequently look at the selling or promotion function of the agency, or the so-called "lobbying function" which is how most agencies perform the marketing function. We shall see the shortcomings of this approach.

It would seem that the central aspect of development is really in terms of market research and the generation of new programs, as one is actually trying to ascertain what the consumer wants and to develop programs to fit his needs, on the assumption that, if one does so, the consumer (i.e., the Legislature and/or the Department of Education) is more likely to buy the end product. What tends to happen in government agencies is an isolation of their market. A group of administrators develops what it feels is an adequate program and then attempts to sell it through a kind of political "brute force", through direct testimony to the Legislature, or by developing political support in the State through advisory committees, or holding public hearings, etc. Selling inside the State Department of Education is fairly standard procedure. The deficiency here, of course, is that you are selling a product developed by an outside agency which may not be geared to the consumer's needs. Unless one is certain of developing a saleable program which the consumer favors at the outset, one has a deficient marketing thrust. It is pointless to develop any program in the absence of information as to consumer preferences; which is why, from the point of view of this analysis, it would be productive if more effort were put into the first two functions: 1) marketing research, and 2) the generation of programs fitting consumer needs. The third aspect then becomes, How do we sell it? What this means, of course, is that the program should be developed to serve consumer needs, rather than to express the aspirations of professionals within the agency. In my brief perusal of some of the literature, I saw a question raised. What is the role of the professional? One finds the professional attempting to define his role in a sense which he feels is appropriate to Rehabilitation. This is a constant search, and it assumes, of course, that if all professionals could agree on the appropriate role, this is the role which should exist.

We can, in terms of program content, draw an analogue with industry as to what the professional role ought to be or would be ... in this case, that of the engineers. One does not find -- or, at least, it does not have any great significance -- automotive engineers getting together at national conventions, or deciding, as a national group, through their respective literature, which is the best automobile, what the role of the automobile is, or what the characteristics of the automobile are supposed to be, reaching a conclusion and having all companies make exactly the same model automobile, in the absence of any consumer response at all. Obviously, automobile companies make what consumers want, not what their engineers think they should make. We are long past the day of Henry Ford who, as you will recall, said you could have any automobile you wanted as long as it was a Model "T", and black.

The last aspect of the marketing function is, of course, whatever future plans may be, both in terms of budget and types of service, **they** must be sold to the client: to both the legislators and the client who is going to use the service. There have been comments on various political devices which are used, and these need not be expanded upon. My only plea here, of course, is that the marketing operation be integrated within itself and also be integrated with the rest of the agency operation. I had hoped, also, that the marketing function could be a continuing forerunner of the selling program, and that one might not "peak out", in other words, throw all of one's effort into a single selling promotion effort at the time of appropriations. That is, that the effort should be continuous. In terms of the actual service to clients by the agency, I am not sure how serious this problem is, -- if you seem to have many more clients than you can possibly service. However, the question is raised from time to time, that people don't know about rehabilitation. It seems to me there would be value in assistance to the legislature in making voters aware of what is being done, through more institutional advertising, with the local legislator's help and cooperation. What does he want done in his area, and how could this best be expressed to the voter, etc. This is assurance that the voter is getting something for his money. I realize, in looking at the entire marketing-program developing function, that there may be laws which will prohibit such activities as have been suggested; or political aspects which could make it inadvisable. The purpose of this analysis, however, was to use the business analogue to indicate what functions ideally, and what, theoretically, could be more fully developed (in the absence of recognizing any constraints) at the present time. It would be worth investigating to see the extent to which the marketing function could be more fully developed.

ENGINEERING FUNCTION

This function I shall go through quite briefly. Information from need analysis and demand analysis by the marketing department is sent to the engineering function, and it is the role of the engineers to develop new programs which will serve consumer needs. If there were a permanent Planning and Programing Bureau, the specific operating function which such a bureau would perform should be clearly spelled out, and the advantages in having this function performed should, also, be spelled out. That is, as currently viewed in terms of present status of organization, such a bureau would perform the marketing and accounting function, which is an evaluative function. Other agencies have manpower and engineering; some, I believe, have financial analysis and, of course, management. If one simply talks about planning and program development as being a good idea, and says that all agencies should have long-term planning, this is not overly persuasive. While one might call the bureau "Planning and Development", within the agency these specific functions are certainly marketing. It must be clearly delineated why these functions must be performed on a continuing basis. Perhaps one should not say that the agency is really developing a "marketing function", because this might appear to be too crude. Obviously, the appropriate terminology and presentation would have to be made, but the essential nature of the function would have to get through so that the value of its performance would be understood by the potential buyer. The question is, if such a bureau were not established, would the marketing function be performed at all, would it be performed by others, or would it be poorly performed? One may also ask, should this unit not be established, what are the limitations with which the agency will find itself working? What other advantages to the agency would accrue, if they go ahead with this bureau?

It seems to me that there could be two strategies followed in the final writing of the Statewide report. One report would be a five-year blueprint, rather specific as to what the agency should do during the next five years. One could say that one should plan a development capability, so that what the agency would do over this time period would be generated by the proposed development bureau. Both of these can be treated or incorporated in a single report. However, one should be cautious about the approach as, the expectation that one can draw up a very exact five-year blueprint to be implemented without future program development or planning or forecasting and accounting being done, would be relatively naive. It is important that the report itself establish that the activity which this report is recommending is important and should be performed on a continuing basis; that it cannot be performed once every five years.

The second strategy actually relates to the question of How does one plan development of a programing capability? One is not concerned with developing a specific program in terms of quantity, or forecasting what programs the agency will be doing in the future; rather, one is planning the development of a unit which will facilitate a subsequent program output.

It seems important, at the outset, that in the Statewide report, the expectations of the readers be clearly explored. One should not set the reader up, for example, to affirm that this report will tell one what to do for the next five years, because then the reader will be looking throug through the balance of the report for a five-year blueprint. Rather, one should approach this, mindful that with certain time limits and some gross aggregates, one can delineate a certain kind of program which may be pursued in the next five years; but this is not really thrust. What really has to be examined, is how an agency gears up its own programing, and here one may delineate this kind of blueprint, a blueprint which will, in turn, generate other blueprints. It is important to inform the readers that there is no final, fixed plan which will be perfect under all circumstances. The report should say: Planning is, itself, a continuing function, and this is how one goes about doing it, and this is what the Statewide agency did in terms of activity at this particular time. The strategy as to format and expectation, in the essential thrust of the Statewide plan, has to be explored, and some of the assumptions underlying what we mean by Statewide Planning have to be brought out in the report itself to assure that the reader does not assume certain things about the Statewide report which are invalid and inconsistent with the content of the report. In terms of finally establishing a permanent planning and development unit, whether a bureau is established or not, what clearly has to be outlined in Statewide planning is a notification for the reader that neither an agency nor a State can honestly expect that, for a short period of time (perhaps within a year), and for a limited amount of money (let's say, a hundred thousand dollars), a complete , ideal blueprint can be developed which does not have to be modified for the next five years. What must be avoided in this report is the attitude that one can call in a consulting firm, which will be around for a few weeks, to draw up a five-year plan, drop the report on someone's desk, and assume that sufficient planning has been done for some five years, -- that one simply converts this into operation, or that the plan, itself, is self-effectuating and one need not worry about planning in the near future. It is important that it be clearly understood that planning of the program is simply to pre-determine a course of action, and that it would be the height of intellectual arrogance to assume that a few people can draw up a detailed blueprint as to what agency behavior should be for five years, without any re-evaluation or determination as to validity, or without analysis as to changing environment, etc.

PROGRAM EVALUATION

Again using the private organization analogue, program evaluation would fall into the accounting function.

As you know, the accounting function has two sub-functions: 1) auditing, and 2) measurement of performance. Auditing relates to assuring that money and resources are properly utilized as authorized, or that individuals within the business organization are not using the resources of the organization for their personal ends. This is simply a matter of assuring that no fraud is occurring, and is necessary to protect the interests of the principals who, in this case, are the stockholders.

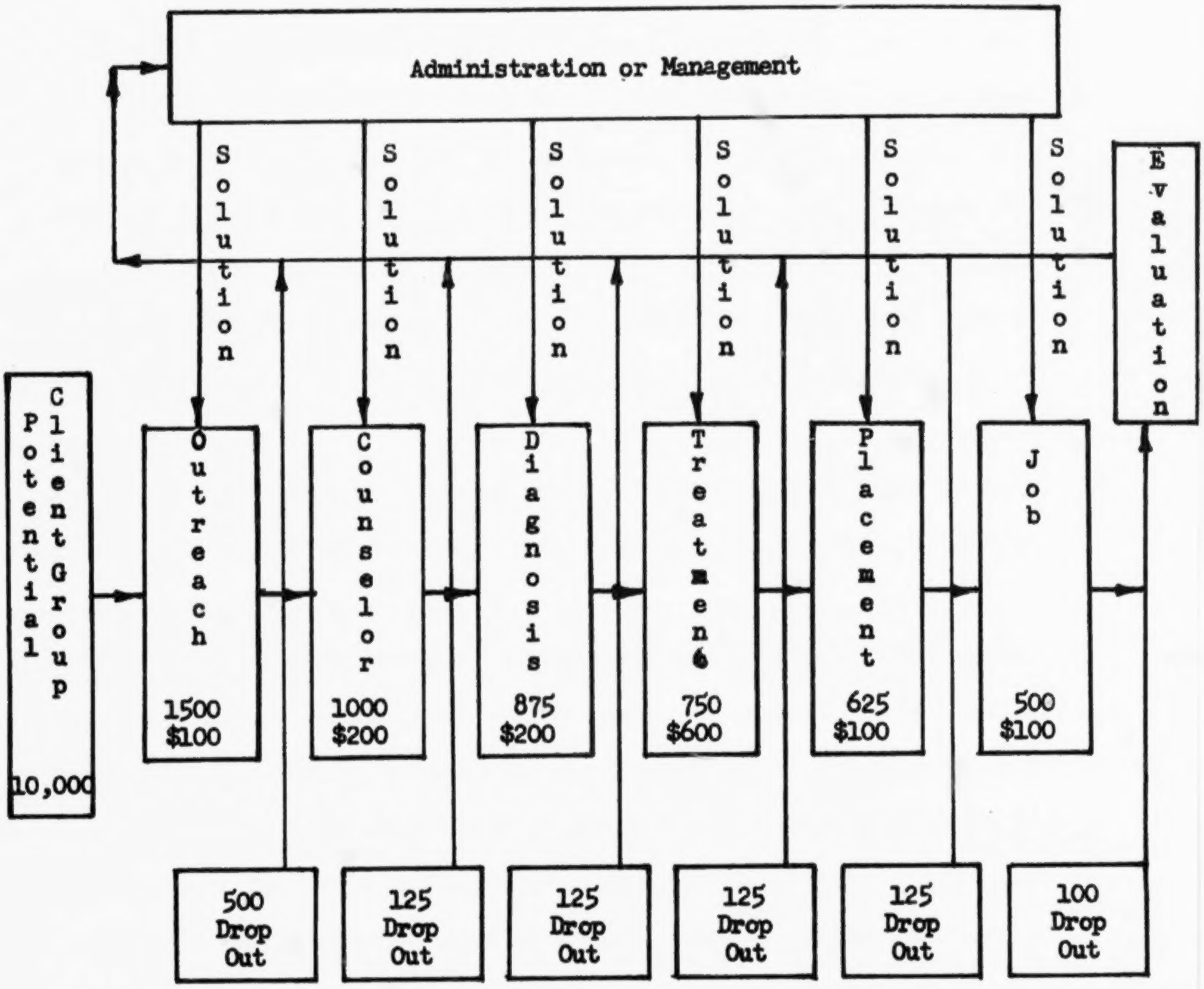
A similar function is performed in government: agencies have both bookkeepers and auditors to assure that money is properly used. It is the second accounting function - measurement of performance - that cost-effectiveness and cost-benefits are concerned with. In the industrial sector, measurement of performance relates to the collection of data which is eventually incorporated into the income statement and tells management whether it is making money or not. One really wants to know if the firm, in a given period of time, is making money or not. What one finds in the public agency is the absence of this particular accounting function. Depending on the purpose of the agency, one would like to know, either, "Did it make any money or not?" or, "Did it accomplish its purpose in an effective and efficient manner?" Unfortunately, agency administration, because it does not have this accounting function, does not receive yearly, quarterly, or monthly profit statements on how well the agency is performing. Although some statistics may be gathered as to certain activities, accounting function is not organized in a manner, as it is in business, actually to get effective data on program performance. The other aspect of the income statement is data as it relates to organization performance, indicating to administration which segments of the organization are performing effectively in an acceptable fashion and which sections are losing money. The data for administration and management indicate organizational weakness where changes have to be made. Looking at both of the functions: 1) auditing functions, and 2) the evaluation function , there is little question that most significant and important is program evaluation. Obviously, more resources will be dissipated through inefficiency than through theft, and it is rather interesting, in the governmental sector, that it is only the auditing of the theft aspect about which people get excited, or with which the present accounting function of the agency is concerned.

The profit concept is also used for investment planning purposes, in that it is the criterion used to choose among future investments, or programs.

The profit concept relates to the fact that it is a ratio. One

CHART VII

PROGRAM EVALUATION FOR ONE YEAR


Administration or Management
Solution
Solution
Solution
Solution
Solution
Solution
Evaluation
Potential Client Group
10,000
Outreach
1500
$100
Counselor
1000
$200
Diagnosis
875
$200
Treatment
750
$600
Placement
625
$100
Job
500
$100
500 Drop Out
125 Drop Out
125 Drop Out
125 Drop Out
125 Drop Out
100 Drop Out

Expected Cost: $1,000,000
Expected Output: 700 Expected Drop Out: 800
Cost per Unit of Output: $\frac{\$1,000,000}{700} = \$1,425$

Actual Cost: $1,087,000
Actual Output: 400 Total Drop Out: 1,100
Cost per Unit of Output: $\frac{\$1,087,000}{400} = \$2,500$

Administrative Problems: Reduce Drop Out; Measure Counselor Performance by Drop Out

wants to know the differential between cost and return. If one is putting money into new programs, one might want to know the percentage return. Granted that public agencies are not profit-making agencies and that they have no economic ends. Therefore, obviously, one cannot use profit criteria. However, the question is not whether one uses profit criteria, the question is whether one incorporates within the accounting function, a data collection device relating to program evaluation. Apart from the difficulties of developing proper or appropriate measurement devices, the real choice is whether one attempts to measure program effectiveness or not. One cannot use the argument that because public agencies are not profit making and because measuring techniques are difficult to develop, no measurement should occur at all; or that there should not be data collecting activity relating to program performance. Something can be better than nothing, and in the absence of such data collection, programs continue to be evaluated, but the evaluation now becomes a matter of subjective preferences, because one has collected no data. I am assuming that not only is this accounting function important, but it would be lodged in the proposed program development bureau. Again, this is a continuing function in that data is constantly being collected, classified, and organized, and analyses presented as to program effectiveness. Industry does not calculate an income statement every five years.

We might look briefly at Chart VII, Program Evaluation for One Year, both to see how data process would work, and what management would do with the data. This chart does not consider the benefit side; it relates to essential cost-effectiveness analysis. We will note in this chart that, again, we have flow-through of the client. Now we have attached numbers both to the number of clients and to the cost of processing a client through a particular sub-process of the total rehabilitation system. At the outset, we have fifteen hundred clients picked up through outreach, at a cost of a hundred dollars per client. As clients are processed through counseling, diagnosis, treatment, placement, and a job, at each of the interfaces, a certain number are dropping out of the system, so that one starts with fifteen hundred and ends up with four hundred, the actual output. At each of the sub-processes, there is a figure: the average cost processed. The counselors are processing one thousand in one year, at two hundred dollars per client. Diagnosis is processing eight hundred and seventy-five at two hundred dollars per client, etc. What one does is aggregate the total cost of the output; which, in this case, is approximately one million dollars, divide by four hundred (output), and this gives us, in terms of the total system, twenty five hundred dollars per unit processed. Note from this chart, that one has data as to the average cost of processing an individual through the entire system, and the average cost of processing a client through each of the sub-units of the system. (Figures are arbitrary, not realistic, for purposes of demonstration.)

Let us suppose that it was expected, rather, that seven hundred would eventually get through, instead of four hundred. This will give us a cost of fourteen hundred dollars per unit processed. You will note that between the expected output and the actual output of clients processed, there exists a difference in cost per client. This difference generates a problem for administration. One then has to go back into the system and find out which particular process is either losing too many clients by dropout rate, or which sub-cost is over-estimating the number and formulate a solution or a procedure which will eliminate this specific difficulty, so that both the actual and expected output will become equal once again.

In order to evaluate programs properly, one is generating two sets of data: one represents expected performance and the other actual performance. This is similar to the method employed by industry in forecasting. For the year in advance, presumably, one has to develop data as to the expected sales volume in terms of the number and price at which products are going to be sold, and the expected cost or standard cost of producing these items, and has, consequently, an expected profit figure. One runs an actual performance by way of sales, costs, and profits, against those expected; and if a differential exists, management has to look into the situation. Thus we find, in the accounting area, particularly on the cost side, a highly developed system of standard costs, budgeting, and quantity output, all of which is directed toward expected future performance.

At the counselor level, we may expect that the counselor will have a set of data as to certain diagnosis and treatment as executed; one may assume a certain measure of effectiveness. There is an expected future performance, and associated with this, a set of costs. If the counselor matches diagnosis and treatment and placement, or, in other words, if the counselor processes the client properly through the system, we may expect certain results. There are two basic reasons why expected and actual performance may not be equal. One relates to the counselor: if there is a mismatch, that is, if the counselor does not match diagnosis with treatment, there will not be any change in the characteristics of the clients. The other basic reason might be where the expected match between diagnosis and treatment is incorrect. Let us suppose that the counselor is told that, if a narcotic addict is placed in a halfway house by way of treatment, he will develop certain social and communication skills, and change in certain attitudes, but, in fact, this does not occur in the halfway house. Under these circumstances, which are not the fault of the counselor, such clients must be fed back into the larger network management because of deficient mental facilities. One looks at the technology again and either changes it so that it is more effective, or else changes the data as to expectation and risk involved, so that the counselor can make a better calculation. In any kind of evaluation, you have to look at the end product emerging from the system.

The results of the vocational rehabilitation system must be measured against the original objectives which were established. These results must also be measured against the costs of the vocational rehabilitation system, This final evaluation draws together all the elements in the vocational rehabilitation system and serves as the device to effect short run and long run changes in the system. It is the monitoring device which enables the system to adjust to an ever-changing environment.

CHOOSING OBJECTIVES
BY
BENEFIT ANALYSIS

Prepared by:

Frank C. Grella   Donna L. Friedeberg

In recent years the techniques of cost-benefit analysis have been used to measure the effectiveness of many governmental programs. Although the cost-benefit techniques were originally used in evaluation of water resource and other projects, the techniques have been recently applied to investments in programs dealing with improvement of human resources such as Vocational Rehabilitation, Job Corps, and Upward Bound.

The results achieved by Vocational Rehabilitation lead themselves to measurement by these techniques. It is possible to evaluate partially the improvement of a person who has been rehabilitated. The benefits inherent in this improvement accrue to the individual rehabilitant, to the taxpayer who may be relieved of a tax burden, and to the economy as a whole which benefits from the increased productivity of rehabilitated persons. Benefits to the individual, to the taxpayer, and to the economy and their associated costs are reviewed in the following pages.

The benefits which accrue to the individual as a result of Vocational Rehabilitation are represented by the achievement of a gainful occupation which can be measured quantitatively and the possible improvements in physical adaptation, personal adjustment, educational development, economic condition, and communication skills which are qualitative benefits.

The costs involved for the individual rehabilitant in attaining these economic and personal benefits are small. The average length of time which a rehabilitated client spends on the rolls of the Connecticut Division of Vocational Rehabilitation is 1 1/6 years. During this period of time the rehabilitant could have chosen to remain on the rolls of a public assistance agency or in the custodial care of a public institution.

It is possible that during this period of rehabilitation training or retraining he is prevented from earning any income so that he must subsist on the maintenance allowances provided by Vocational Rehabilitation or allowances from his family or friends.

Since the personal benefits received by rehabilitated clients cannot be measured in dollar values, the technique most commonly used to measure benefits is the computation of the increase in lifetime earnings which has resulted from Vocational Rehabilitation services. As shown in the following table, there is a sharp increase in the lifetime earnings of the rehabilitated. The calculation of these lifetime earnings has been made for the 1547 clients rehabilitated in Connecticut in Fiscal Year 1966-1967. (The same procedure will be followed for the 1967-1968 data which is presently being compiled.)

Description of Table I

Part I of Table I includes the lifetime earnings of:

1390 clients who entered the competitive labor market
78 who entered sheltered workshops
13 who became self-employed
1 who entered a state agency managed business

Part II of the table shows projected lifetime earnings for 227 clients who were working and earning incomes at the time of their acceptance into the Vocational Rehabilitation program. It is assumed that these earnings would have continued without the benefit of Vocational Rehabilitation.

Part III and IV of the table show the estimated lifetime dollar value of the work activity at closure and at acceptance of:

56 homemakers
7 unpaid family workers

Estimated Lifetime Earnings* and Service Values For Rehabilitated Clients

At Acceptance and at Closure

Dollar Amount

I	Lifetime earnings of rehabilitated clients based on earnings at closure (other than homemakers and unpaid family workers)	+86,360,000	
II	Lifetime earnings of rehabilitated clients based on earnings at acceptance (other than homemakers and unpaid family workers)		-5,930,000
III	Estimate of value of service rendered by homemakers and unpaid family workers at closure	+ 1,570,000	
IV	Estimate of value of services rendered by homemakers and unpaid family workers at acceptance		- 70,000

Net Increase in lifetime earnings +81,930,000

*The data represent 1547 clients rehabilitated in 1966-1967 in Connecticut. The method used for deriving these estimates is available upon request.

Figures rounded to the nearest ten thousand.

The benefits to the taxpayer occur in the form of reduced dependency on Public Assistance and reduction of the number of those who are in public institutions such as mental hospitals and sanitoria. The decrease of dependence on Public Assistance which amounted to $121,404 per year for the 1966-1967 rehabilitated clients must be considered for an extended period of time. If the savings in Public Assistance is based on a five year period, then the total dollars saved amounts to $607,020.

Of the clients rehabilitated in 1967, 182 came from various public institutions. The cost of maintaining this group in public institutions was approximately $54,00 per month. The average length of time rehabilitated clients would have spent in an institution if it were not for VR is not definitely known, however, if one year is taken as the average, the savings would amount to $650,000.

The cost to the taxpayer is his contribution in taxes to support the rehabilitation program.

The operation of the Connecticut Labor Market benefits because of the wide spectrum of occupations which rehabilitants enter or return to. Those occupations include, for instance, the machine trades which are presently very much in need of qualified persons. The cost to employers is represented by that portion of their tax bill which supports the work of Vocational Rehabilitation.

The effect of Vocational Rehabilitation on the Gross National Product occurs primarily as the result of the additional lifetime earnings of the rehabilitated clients. These earnings of the 1966-1967 rehabilitated resulted in additional consumption, annual increased income tax of $445,800, and yearly increased sales tax revenues of $26,700. The increase in the Gross National Product benefits all members of the economy.

CHOOSING OBJECTIVES BY BENEFIT ANALYSIS

The techniques of cost benefit analysis can be used to demonstrate the costs and benefits associated with the achievement of the objectives of the vocational rehabilitation system. These costs and benefits accrue to various groups such as the rehabilitants, the taxpayers, the labor market participants, and the economy in general. The benefits for all concerned with vocational rehabilitation are derived from a program which serves essentially on a random basis. That is, no attempt is made to single out certain types of vocationally disabled who will be processed. The composition of the clientele rehabilitated, therefore is shaped by chance rather than by intent. Similarly the budget allocated to the vocational rehabilitation system by the state and federal governments, which is based on estimates of budgetary needs within a particular fiscal period, is strongly affected by political and private pressures.

The techniques of cost benefit analysis can be used to show that a more logical examination of objectives within a cost framework is possible by calculating various results which occur from various chosen sets of objectives. The decision maker should be able to make better decisions based on quantitative measures. The decision maker will at times, however, be influenced by factors other than the quantitative data which is available to him. Political and private pressures may dictate programs other than those which seem most advantageous economically. If he does make decisions based on other than quantitative factors he will know the significance of his decisions in terms of costs to be incurred and benefits to be achieved. In the following pages the effect on costs and benefits which result from varying the objectives of the vocational rehabilitation system will be shown. Four examples with 2000 rehabilitants each will be presented. Each of these examples will attempt to accomplish different objectives:

1. to increase personal benefits to the rehabilitants.
2. to increase the earnings of the rehabilitants.
3. to increase benefits to taxpayers by reducing public assistance and dependency on public institutions.
4. to increase benefits to the participants in the labor market.

The final effects on the economy result from whichever of these alternatives is selected.

To Increase Personal Benefits to the Rehabilitants

The individuals rehabilitated by the vocational rehabilitation system benefit from improvement of such personal characteristics as: physical adaptation personal adjustment, educational development, economic condition, and communication skills. These personal improvement factors cannot be measured quantitatively in the same manner as it is possible to measure increases in earnings which result from securing a gainful occupation.

However, it is possible, by examining certain quantitative data, to determine which group of disabled clients has received the largest number of personal improvements. A method by which this can be done is described in Footnote 1 which accompanies Table I below.

The Index of Non-Quantitative Benefits for rehabilitated individuals with particular disabilities is highest (as shown in Table I) for those individuals with speech impairments, Disability Category 680-689. Cost and benefits associated with the rehabilitation of this group indicated that the average case service costs for those with speech impairments was $507.00; the Index of Non-Quantitative Benefits was 300. The rehabilitants with speech impairments had average change in weekly earnings between acceptance and rehabilitation of $47.00. The earnings aspect of rehabilitation will be discussed later.

Suppose the individual who must decide upon the number of clients in each of the disability categories who will receive rehabilitation services decides that he will allocate the resources available to him in proportion to the personal benefits received by the rehabilitants in the individual disability categories. Using as a guide the Indices of Non-Quantitative Benefits as presented in Table I, the decision maker would anticipate a breakdown of rehabilitants by disability category, as shown in Table II. In Table II a projected group of 2000 rehabilitants has been spread among the various disability categories in proportion to the Indices of Non-Quantitative Benefits which were shown in Table I. The largest number of persons to be rehabilitated is within the Speech Impairment category since, according to the Indices, individuals in this particular disability category

TABLE I

Costs and Benefits by Disability Category

VRA Codes	Disability Categories	Number Rehabilitated	Average Case Service Costs per Client	Average Change in Weekly Earnings	Index of Non-Quantitative Benefits[1]
100-119	Blindness	170	570	--	--
120-149	Other Visual Impairments	35	410	54	265
200-219 -220-229	Deafness and Other Hearing Impairments	81	464	68	280
300-319	Orthopedic - Paraplegia	16	688	114	225
320-339	Orthopedic - Hemiplegia	39	705	59	212
340-359	Orthopedic - One or Both)	--	--	--	--
360-379	Orthopedic - Upper or Lower)	130	702	58	227
380-399	Orthopedic - Other	71	170	65	200
400-449	Absence or Amputation of Members	65	637	51	219
500	Psychotic Disorders	161	335	59	236
510	Psychoneurotic Disorders	147	285	60	242
520 521 522	Alcoholism Drug Addiction Other Character, Personality and Behavioral Disability	219	258	65	242
530	Mild Mental Retardation	149	337	58	263
532	Moderate Mental Retardation	157	381	49	205
534	Severe Mental Retardation	37	812	26	241
600-609	Cancer	2	57	98	100
610-619	Allergic, Endocrine System, Metabolic and Nutritional	16	446	70	214
620-629	Diseases of the Blood	1	21	90	300
630	Epilepsy	32	426	55	230
639	Other Disorders of the Nervous System	5	232	55	230
640-644	Cardiac Conditions	59	410	58	216
645-649	Other Circulatory Conditions	7	18	58	216
650-659	Respiratory Diseases	59	276	65	243
660-669	Digestive System Disorders	20	329	36	255
670-679	Genito-Urinary System Conditions	--	--	--	--
680-689	Speech Impairments	24	507	47	300
690-699	Others (not elsewhere classified)	13	420	68	254
	TOTAL	1,547	--	--	--

Source: Compiled from data covering 1,547 persons rehabilitated in fiscal year 1966-1967; for the Division of Vocational Rehabilitation, Department of Education, State of Connecticut.

See footnote[1] on following page.

---

[1] Rehabilitants in each of the disability categories receive personal benefits which include: physical adaptation, personal adjustments, educational development, increased communication, and economic improvement. These benefits have usually been considered non-quantifiable. An example of an attempt to quantify these data, however, follows. There were forty rehabilitants in fiscal year 1966-1967 who had impairment of the limbs. Of this group, one received none of the benefits described above; fourteen (or 35%) received physical adaptation benefits; twenty-five (or 63%) received personal adjustment benefits; sixteen (or 40%) received educational benefits; and thirty-seven of the forty (or 93%) received economic benefits. These percentages were summed and yielded a total of 244. This total was then taken as an Index of Non-quantitative Benefits for the disability category of Impaired Limbs. An Index of Non-quantitative Benefits was calculated in the same manner for each of the other disability categories. This procedure eliminated the numeric size of the individual disability categories, so that the benefits received by each disability group could be compared.

receive the largest number of personal benefits each as a result of vocational rehabilitation.

The case service costs for rehabilitating 2000 persons based on the proportions of the personal benefits received by the individual disability categories is $861,200 (see Table II). The decision to rehabilitate the projected group of 2000 on the basis of personal benefits also has effects on the increase in yearly earnings between acceptance and closure; the increase in revenues from the sales tax, the income tax, and the Social Security contributions; savings in public assistance; and decrease in dependence on custodial care of public institutions. These data are shown in Table III. Personal benefits to the 2000 rehabilitants in this example are also shown in Table III.

The decision to rehabilitate individuals on the basis of improvement of personal benefits must also be considered in relation to the number of individuals with each specific impairment in the proposed group of rehabilitants. Because of a limited number of persons in several categories, the rehabilitation system might not be able to reach the desired number of persons in each of the individual categories. The decision to choose the composition of the expected rehabilitants on the basis of improvement of personal benefits must also be reviewed in the light of the work and life expectancy of the groups chosen.

To Increase the Earnings of Rehabilitants

Another alternative open to the decision maker is to choose to proportion the number of rehabilitants in relation to the various changes in average weekly earnings of the disability categories.

TABLE II

Case Service Costs for Rehabilitating 2000 Vocationally Disabled Persons With the Objective of Increasing Personal Benefits[1] to the Rehabilitants

VRA Codes	Disability Categories	Number to be Rehabilitated	Average Case Service Costs per Rehabilitant	Total Case Service Costs
100-119	Blindness	--	--	--
120-149	Other Visual Impairments	98	490	48,020
200-219 220-229	Deafness and Other Hearing Impairments	104	464	48,256
300-319	Orthopedic - Paraplegia	84	688	57,792
320-339	Orthopedic - Hemiplegia	78	705	54,990
340-359	Orthopedic - One or both	90	702	63,180
360-379	Orthopedic - Upper or lower	80	702	56,160
380-399	Orthopedic - Other	74	170	12,580
400-449	Absence or Amputation of Members	80	637	50,960
500	Psychotic Disorders	88	335	29,480
510	Psychoneurotic Disorders	90	285	25,650
520 521 522	Alcoholism Drug Addiction Other Character, Personality and Behavioral Disability	90	258	23,220
530	Mild Mental Retardation	98	337	33,026
532	Moderate Mental Retardation	76	381	28,956
534	Severe Mental Retardation	90	812	73,080
600-609	Cancer	36	57	2,052
610-619	Allergic, Endocrine System, Metabolic and Nutritional	80	446	35,680
620-629	Diseases of the Blood	110	21	2,310
630	Epilepsy	--	--	--
639	Other Disorders of the Nervous System	86	372	31,992
640-644	Cardiac Conditions	--	--	--
645-649	Other Circulatory Conditions	80	410	32,800
650-659	Respiratory Diseases	90	276	24,840
660-669	Digestive System Disorders	94	329	30,926
670-679	Genito-Urinary System Conditions	--	--	--
680-689	Speech Impairments	110	507	55,770
690-699	Others (not elsewhere classified)	94	420	39,480
	TOTALS	2,000		$861,200

Source: Compiled from data covering 1,547 persons rehabilitated in fiscal year July 1, 1966 to June 30, 1967, for the Division of Vocational Rehabilitation, Department of Education, State of Connecticut

[1] Personal Benefits include improvement in Physical Adaptation, Personal Adjustment, Educational Development, Economic Condition, and Communication Skills.

See footnote[2] on following page.

[2] Rehabilitants in each of the disability categories receive personal benefits which include: physical adaptation, personal adjustments, educational development, increased communication, and economic improvement. These benefits have usually been considered non-quantifiable. An example of an attempt to quantify these data, however, follows: There were forty rehabilitants in fiscal year 1966-1967 who had impairment of the limbs. Of this group, one received none of the benefits described above; fourteen (or 35%) received physical adaptation benefits; twenty-five (or 63%) received personal adjustment benefits; sixteen (or 40%) received educational benefits; and thirty-seven of the forty (or 93%) received economic benefits. These percentages were summed and yielded a total of 244. This total was then taken as an Index of Non-quantitative Benefits for the disability category of Impaired Limbs. An Index of Non-quantitative Benefits was calculated in the same manner for each of the other disability categories. The Indices for each of the categories were then totaled. Each Index of a disability category was taken as a proportion of the total of the Indices. The 2,000 rehabilitants were then distributed into the categories according to these proportions.

TABLE III

Effects on Other Benefits as a Result of Rehabilitating 2000 Vocationally Disabled Persons with the Objective of Increasing Personal Benefits to the Rehabilitants

QUANTITATIVE

Benefits	Amount
Yearly Increase in:	
Earnings	$8,236,540
Income Tax	690,705
Sales Tax	40,878
Social Security Contributions	310,112
Yearly Savings in:	
Public Assistance	$ 156,528
Public Institutions	947,540

QUALITATIVE

Personal Benefits for the Rehabilitants	$ 482,794[1]

---

[1] Rehabilitants in each of the disability categories receive personal benefits which include: physical adaptation, personal adjustments, educational development, increased communication, and economic improvement. These benefits have usually been considered non-quantifiable. An example of an attempt to quantify these data, however, follows. There were forty rehabilitants in fiscal year 196601967 who had impairment of the limbs. Of this group, one received none of the benefits described above; fourteen (or 35%) received physical adaptation benefits; twenty-five (or 63%) received personal adjustment benefits; sixteen (or 40%) received educational benefits; and thirty-seven of the forty (or 93%) received economic benefits. These percentages were summed and yielded a total of 244. This total was then taken as an Index of Non-quantitative Benefits for the disability category of Impaired Limbs. An Index of Non-quantitative Benefits was calculated in the same manner for each of the other disability categories. This procedure eliminated the numeric size of the individual disability categories so that the benefits received by each disability group could be compared. The indices for each of the disability categories were multiplied by the number of projected clients in each disability category. These numbers were then summed to arrive at the sum of the Qualitative Benefits for the entire projected group. The sum of Qualitative Benefits was used for comparison with those of the other projected groups. (See Tables V, VII, and IX.)

This decision would strongly effect the returns from the income tax, the sales tax, and social security contributions. The cost of such a decision based on a projected group of 2000 rehabilitants would be $783,149 (see Table IV). The disability group which would have the largest number of rehabilitants would be the cancer category. The number in the cancer category on which this projection is based was so small, however, that the data taken from it which support this conclusion is rather meager and the decision maker would have to consider whether to alter his decision since the number of persons normally rehabilitated in the cancer category is very small.

The effects of this alternative on the quantitative factors such as yearly earnings at closure; savings for a year in public assistance and other items is shown in Table V. The effect on the qualitative benefits, namely the personal benefits for the group and the improvement in the operation of the labor market are also shown in Table V.

To Increase Benefits to Taxpayers

The decision maker may choose to rehabilitate those individuals who are dependent on public assistance or public institutions in an attempt to improve the benefits of the vocational rehabilitation program to the taxpayers. If this decision is made, the rehabilitants are sought among those in public institutions. The rehabilitants would be mainly those with mental disorders or mental retardation. The composition of the projected rehabilitants would be as it is shown in Table VI. The resulting cost of this decision would be $793,120 for case services. The effects on the other benefits which result from the vocational rehabilitation system are shown in Table VII.

TABLE IV

Case Service Costs for Rehabilitation of 2000 Vocationally Disabled Persons With the Objective of Increasing the Total Earnings for the Rehabilitants

VRA Codes	Disability Categories	Number to be Rehabilitated	Average Case Service Costs per Rehabilitant	Total Case Service Costs
100-119	Blindness	--	--	--
120-149	Other Visual Impairments	80	490	39,200
200-219 220-229	Deafness and Other Hearing Impairments	100	464	46,400
300-319	Orthopedic - Paraplegia	65	688	44,720
320-339	Orthopedic - Hemiplegia	87	705	61,335
340-359	Orthopedic - One or both	85	702	59,670
360-379	Orthopedic - Upper or lower	85	702	59,670
380-399	Orthopedic - Other	95	170	16,150
400-449	Absence or Amputation of Members	75	637	47,775
500	Psychotic Disorders	87	335	29,145
510	Psychoneurotic Disorders	88	285	25,080
520 521 522	Alcoholism Drug Addiction Other Character, Personality and Behavioral Disability	95	258	24,510
530	Mild Mental Retardation	85	337	28,645
532	Moderate Mental Retardation	72	381	27,432
534	Severe Mental Retardation	38	812	30,856
600-609	Cancer	144	57	8,208
610-619	Allergic, Endocrine System, Metabolic and Nutritional	103	446	45,938
620-629	Diseases of the Blood	133	21	2,793
630 639	Epilepsy Other Disorders of the Nervous System	81	372	30,132
640-644	Cardiac Conditions	--	--	--
645-649	Other Circulatory Conditions	85	410	34,850
650-659	Respiratory Diseases	95	276	26,220
660-669	Digestive System Disorders	53	329	17,437
670-679	Genito-Urinary System Conditions	--	--	--
680-689	Speech Impairments	69	507	34,983
690-699	Others (not elsewhere classified)	100	420	42,000
	TOTALS	2,000		$783,149

Source: Compiled from data covering 1,547 persons rehabilitated in fiscal year July 1, 1966 to June 30, 1967, for the Division of Vocational Rehabilitation, Department of Education, State of Connecticut

See footnote[1] on following page.

---

[1] The average category change in weekly salary ($59), of the 1,547 clients rehabilitated in fiscal year 1966-1967, was taken as a base of 100. The average weekly change in salary for each of the disability categories was then divided by the category average change in weekly salary and multiplied by 100 to arrive at the indices for each category. For example, the weekly change in salary for those in the Speech Impairment Category (680-689) was $47. Dividing $47 by $59 yields an Index of Change in Weekly Earnings of 80 for this particular category. The Indices of Change in Weekly Earnings were totaled. The sum which resulted was 2,306. To determine what proportion of the rehabilitants should be in the Speech Impairment Category, using the criteria of increases in earnings, the index of 80 for those with speech impairments was divided by 2,306, and the result was multiplied by 2,000 (the projected number of rehabilitants). The result of 69 indicated that 69 persons should be rehabilitated in this disability category.

TABLE V

Effects on Other Benefits as a Result of Rehabilitating 2000 Vocationally Disabled Persons with the Objective of Increasing Total Earnings for the Rehabilitants

Benefits	Amount
QUANTITATIVE	
Yearly Increase in:	
Earnings	$7,215,780
Income Tax	605,105
Sales Tax	35,812
Social Security Contributions	271,860
Yearly Savings in:	
Public Assistance	$ 156,528
Public Institutions	947,540
QUALITATIVE	
Personal Benefits for the Rehabilitants	463,747[1]

---

[1] See footnote[1], Table III

TABLE VI

Case Service Costs for Rehabilitating 2000 Vocationally Disabled Persons with the Objective of Decreasing Public Assistance and Dependency on Public Institutions

VRA Codes	Disability Categories	Number to be Rehabilitated[1]	Average Case Service Costs per Rehabilitant	Total Case Service Costs
100-119	Blindness	--	--	--
120-149	Other Visual Impairments	40	490	19,600
200-219 220-229	Deafness and Other Hearing Impairments	60	464	27,840
300-319	Orthopedic - Paraplegia	20	688	13,760
320-339	Orthopedic - Hemiplegia	60	705	42,300
340-359	Orthopedic - One or both	40	702	28,080
360-379	Orthopedic - Upper or lower	120	702	84,240
380-399	Orthopedic - Other	80	170	13,600
400-449	Absence or Amputation of Members	60	637	38,220
500	Psychotic Disorders	220	335	73,700
510	Psychoneurotic Disorders	180	285	51,300
520 521 522	Alcoholism Drug Addiction Other Character, Personality and Behavioral Disability	320	258	82,560
530	Mild Mental Retardation	220	337	74,140
532	Moderate Mental Retardation	220	381	83,820
534	Severe Mental Retardation	60	812	48,720
600-609	Cancer	--	57	--
610-619	Allergic, Endocrine System, Metabolic and Nutritional	20	446	8,920
620-629	Diseases of the Blood	--	21	--
630	Epilepsy	--	--	--
639	Other Disorders of the Nervous System	60	372	22,320
640-644	Cardiac Conditions)	80	410	32,800
645-649	Other Circulatory Conditions)			
650-659	Respiratory Diseases	80	276	22,080
660-669	Digestive System Disorders	20	329	6,580
670-679	Genito-Urinary System Conditions	--	--	--
680-689	Speech Impairments	20	507	10,140
690-699	Others (not elsewhere classified)	20	420	8,400
	TOTALS	2,000		$793,120

Source: Compiled from data covering 1,547 persons rehabilitated in fiscal year July 1, 1966 to June 30, 1967, for the Division of Vocational Rehabilitation, Department of Education, State of Connecticut

See footnote[1] on following page.

---

[1] In order to determine the distribution of the projected 2,000 rehabilitants into the individual disability categories, the following assumptions were made:

The 1,320 rehabilitants in the fiscal year 1966-1967 who reported no income at acceptance for services, were considered to be representative of those in institutions and those receiving public assistance. The percentage distribution of this group was used as the basis for allocating the 2,000 projected rehabilitants, as shown in Table VI.

TABLE VII

Effects on Other Benefits as a Result of Rehabilitating 2000 Vocationally Disabled Persons with the Objective of Decreasing Public Assistance

QUANTITATIVE

Benefits	Amount
Yearly Increase in:	
Earnings	$6,795,620
Annual Income Tax	665,971
Sales Tax	39,415
Social Security Contributions	299,007
Yearly Savings in:	
Public Assistance	$ 782,640
Public Institutions	5,219,500

QUALITATIVE

Personal Benefits for the Rehabilitants	$ 470,520[1]

---

[1] See footnote[1], Table III

To Increase Benefits to the Participants in the Labor Market

The decision maker may also choose to rehabilitate persons in accordance with the needs of the labor market. One way by which this can be done is by proportioning the projected rehabilitants (2000) in inverse relation to the unemployment situation within particular occupational groups. That is, if there is a low-level of unemployment among workers in machine trades, which indicates an apparent demand for these workers, then the rehabilitation objectives would be aimed at rehabilitating more workers who could be employed in the machine trade. The results of such a decision are shown in Table VIII. The costs of rehabilitating 2000 individuals, with emphasis on the needs of the labor market, is $803,453 for services.

In this example the primary benefits to the labor market participants will be considered to be the reduction of unemployment and the provision of those types of workers who are in short supply.

The results of the decisions generated by each of these examples is summarized in Table X. On the basis of the estimates of rehabilitating 2000 persons the most desirable alternative seems to be example I which shows the largest annual amount of earnings and the most personal benefits. However, two important reservations must be made:

1. The data shown are only for one year. A true cost-benefit analysis would have to take into consideration a much longer period of time. It would have to consider death rates and drop out rates for the individuals in the particular alternative chosen.

2. The greatest increase in tax revenues is contingent upon the decision which stresses the income received by the rehabilitated individual. The tax is derived from the results of the rehabilitation and is a function of the income level attained by the rehabilitants.

TABLE VIII

Case Service Costs for Rehabilitating 2000 Vocationally Disabled Persons
With the Objective of Benefiting Participants in the Connecticut Labor Market

VRA Codes	Disability Categories	Number to be Rehabilitated[1]	Average Case Service Costs per Rehabilitant	Total Case Service Costs
100-119	Blindness	--	--	--
120-149	Other Visual Impairments	31	490	15,190
200-219 220-229	Deafness and Other Hearing Impairments	93	464	43,152
300-319	Orthopedic - Paraplegia	9	688	6,192
320-339	Orthopedic - Hemiplegia	30	705	21,150
340-359	Orthopedic - One or both	34	702	23,868
360-379	Orthopedic - Upper or lower	94	702	65,988
380-399	Orthopedic - Other	173	170	29,410
400-449	Absence or Amputation of Members	236	637	150,332
500	Psychotic Disorders	219	335	73,365
510	Psychoneurotic Disorders	149	285	42,465
520 521 522	Alcoholism Drug Addiction Other Character, Personality and Behavioral Disability	287	258	74,046
530	Mild Mental Retardation	193	337	65,041
532	Moderate Mental Retardation	168	381	64,008
534	Severe Mental Retardation	58	812	47,096
600-609	Cancer	4	57	228
610-619	Allergic, Endocrine System, Metabolic and Nutritional	12	446	5,352
620-629	Diseases of the Blood	2	21	42
630	Epilepsy	--	--	--
639	Other Disorders of the Nervous System	32	372	11,904
- 640-644	Cardiac Conditions			
645-649	Other Circulatory Conditions	72	410	29,520
650-659	Respiratory Diseases	47	276	12,972
660-669	Digestive System Disorders	28	329	9,212
670-679	Genito-Urinary System Conditions	--	--	--
680-689	Speech Impairments	20	507	10,140
690-699	Others (not elsewhere classified)	9	420	3,780
	TOTALS	2,000		$803,453

Source: Compiled from data covering 1,547 persons rehabilitated in fiscal year July 1, 1966 to June 30, 1967, for the Division of Vocational Rehabilitation, Department of Education, State of Connecticut

---

[1] See footnote[1] on following page.

[1] Possible occupations into which the projected rehabilitants could go were grouped into categories used by the Connecticut Labor Department: professional-managerial; clerical-sales; service trades; farm, fish, and forest workers; processing industries; machine trades; bench workers; structural employees; miscellaneous.

The percentage of the Connecticut unemployed which falls into each of these categories was taken from the Connecticut Labor Department Monthly Bulletin of April 1967, "Manpower Report, 1967" p. 11. Each of these percentages was divided into one to obtain an inverse relationship to unemployment. These figures were then summed, and the proportion of each to the sum was found.

The 2,000 projected rehabilitants were divided among the occupational categories according to these proportions. The number of clients in each occupational category was then distributed over the disability categories according to proportions found in the occupations at closure of the 1,547 clients rehabilitated in fiscal year 1966-1967.

TABLE IX

Effects on Other Benefits as a Result of Rehabilitating 2000 Vocationally Disabled Persons with the Objective of Benefiting Participants in the Connecticut Labor Market

Benefits	Amount
QUANTITATIVE	
Yearly Increase in:	
Earnings	$6,938,880
Income Tax	581,884
Sales Tax	34,438
Social Security Contributions	261,254
Yearly Savings in:	
Public Assistance	$ 156,528
Public Institutions	947,540
QUALITATIVE	
Personal Benefits to the Rehabilitants	$ 467,036[1]

---

[1] See footnote[1], Table III

TABLE X

Summary of Benefits Attained When Varying the Objectives of the Vocational Rehabilitation System for 2000 Rehabilitants

	ANNUAL INCREASE			
Objective	Earnings	Income Tax	Sales Tax	Social Security
Increasing Personal Benefits[1] to the Rehabilitants	8,236,540	690,705	40,878	310,112
Increasing Total Earnings[2] for the Rehabilitants	7,215,780	605,105	35,812	271,860
Decreasing Public Assistance and Dependence on Public Institutions[3]	6,795,620	665,971	39,415	299,007
Benefiting the Participants in the Connecticut Labor Market[4]	6,938,880	581,884	34,438	261,254

	ANNUAL SAVINGS		NON-QUANTITATIVE BENEFITS
Objective	Public Assistance	Public Institutions	Personal Benefits
Increasing Personal Benefits[1] to the Rehabilitants	156,528	947,540	482,794
Increasing Total Earnings[2] for the Rehabilitants	156,528	947,540	463,747
Decreasing Public Assistance and Dependence on Public Institutions[3]	782,640	5,219,500	470,520
Benefiting the Participants in the Connecticut Labor Market[4]	156,528	947,540	467,036

[1] See Table III

[2] See Table V

[3] See Table VII

[4] See Table IX

SUMMARY OF TESTIMONY PRESENTED AT A PUBLIC HEARING HELD AT THE STATE CAPITOL, MAY 14, 1968 UNDER THE AUSPICES OF THE PLANNING COUNCIL FOR VOCATIONAL REHABILITATION SERVICES

WELCOMING ADDRESS ------- THE HONORABLE JOHN N. DEMPSEY, GOVERNOR OF CONNECTICUT

KEYNOTE SPEAKER --------- THE HONORABLE ELLA T. GRASSO, SECRETARY OF STATE, CONNECTICUT

INTRODUCTORY SPEAKER ---- WILLIAM J. SANDERS, PhD. COMMISSIONER OF EDUCATION

MODERATOR --------------- JOSEPH W. RESS, CHAIRMAN, PLANNING COUNCIL OF VOCATIONAL REHABILITATION SERVICES

PANEL ------------------- CYRUS FLANDERS, STATE LABOR DEPARTMENT, EXECUTIVE SECRETARY OF THE GOVERNOR'S COMMITTEE ON EMPLOYMENT OF HANDICAPPED; KENNETH MCCOLLAM, DIRECTOR, BOARD OF EDUCATION FOR SERVICES OF THE BLIND; MISS ANN SWITZER, EXECUTIVE DIRECTOR OF THE ASSOCIATION FOR RETARDED CHILDREN; ARTHUR DUBROW, STATE OFFICE OF MENTAL RETARDATION; AND GEORGE SANDBORN, PhD., STATE OFFICE OF DEPARTMENTAL PLANNING, STATE DEPARTMENT OF EDUCATION.

Joseph Ress: Governor, it would certainly be presumptuous on my part to assume that you require an introduction to any group of citizens of Connecticut, and particularly, to this group. We know you, not only as our Governor, but also as one who has given superb leadership to the main cause of vocational rehabilitation. So, Governor Dempsey, I take pleasure in presenting to you this group of Connecticut citizens who, by their presence here, indicate that they, too, are vitally interested in vocational rehabilitation; that, under your guidance and leadership, Connecticut maintains its leadership in the future in this field of vocational rehabilitation. Governor Dempsey, I present to you your Planning Council and its guests.

Governor Dempsey: Thank you very, very much. Your distinguished Chairman, my friend, Joe ... Secretary of State, Ella ... It is good to join with you, even so early in the morning. Commissioner Sanders, Cy ... so many old and dear friends ... distinguished guests, ladies and gentlemen:

Joe, that's the kind of introduction, of course, which always pleases the Governor. (Especially after he has just returned from the section of the State, way down in Fairfield County where, late last evening, a young lady tried very hard to introduce him, and wanted to do a real good job by presenting the "Chief Executive of the State of Connecticut". The first time she tried, it just did not come out. The second time ... I just want you to know that I have now been introduced as the "Chief Executioner of the State of Connecticut".) I am very pleased, of course, to greet the Connecticut Planning Conference for Vocational Rehabilitation Services at its Statewide Conference. I have been hoping for the opportunity to express to Chairman Ress, to the other members of the Council, my sincere thanks and my deep appreciation for a service of special importance to the State of Connecticut. You know I have said to Ella many, many times that many of these groups we have, although they are not sensational (and I am sure today we will not generate any headlines), are valuable. It matters that you have taken a moment today in your busy lives to come here to help someone else; and if, among all the speeches that you are going to hear, you hear what you most need to hear this morning, I am very grateful for it. You know recent experience in Connecticut in fields of mental health and mental retardation has shown us the greatness of Connecticut's services for the mentally ill and the mentally retarded, which are a model for the Nation. I am confident that, with the help that you have willingly volunteered, we can develop an equally outstanding program of services for all who require rehabilitation to overcome physical or mental handicaps.

The Master Plan, now in preparation, will call for full rehabilitation services by 1975 for every handicapped person who can benefit from such services. Chairman Ress has placed the total of Connecticut citizens needing services at 60,000. In a State where the population is rapidly growing, we must expect that, by 1975, this figure will be higher. So this presents to all of us a challenge of considerable proportions. But Connecticut has met similar challenges in the past, and I am confident that we can and will do so again. Now, as you know the basic purpose of this Conference is three-fold. It is intended to (1) involve citizen participation in the planning process (2) further inform the Council and the public of the needs of the disabled and (3) institute a dialogue - and all this is so important - institute a dialogue among citizens, the present and future services to the disabled. Now all of this, it seems to me, will serve the needed purpose of shedding added light and increased understanding of the problems faced by those who need the assistance of their fellow citizens in order to be able to engage in useful productive work. It is not charity. Indeed, it is just the opposite. Without rehabilitation, many of the handicapped and disabled must depend on charity from public or private sources for the necessities of life. Rehabilitation removes men and women from the charity role. It takes away the "handout" and offers a "hand-up". Rehabilitation puts people to work. It gives them dignity. It gives them self-respect. It gives them purpose in life. We have, of course, an obligation to provide food, clothing and shelter for those who lack them. But how much more we do for the destitute when we give them a chance ... when we give them a chance to earn those things for themselves. So Joe, I am delighted that you have asked me to come by this morning. My heartfelt gratitude is expressed to all who are engaged in this great work. I think, Ella, you and I hear from people who work at it, every day, whether it is mental health, mental retardation... I think that we can both say to you that if ever in the history of Connecticut, if ever in the history of the United States we need a good understanding, we need your help, God knows it is today. So I come here to bid you welcome, but, most of all, to thank you for all of the people of the State, and particularly for myself. You know, someday in the distant future, people may remember these people who came to the Capitol early one busy morning because they were concerned, not only for their State or Nation, but concerned about others. So, may today's conference be most successful in furthering the all-important task that all of us are undertaking. Thank you so very much.

Mr. Ress: We're sorry, Governor, that there were not more people here to hear your message. I want to thank you so very much for taking time out of your busy day. I know this is a very rough day for you. Again, I say that we should have had more people here.

Governor: Don't ever be discouraged, Joe. If you have two people, you have a majority. We found that out, Ella, didn't we? We have had task forces ... Clean Air Task Force, Clean Water Task Force. We have had five and eight hundred in attendance, but how many do you actually think did the work? Just a couple of you. And doggone it, you'll get the work done!

Mr. Ress: I could certainly introduce our next guest in the way I presented the Governor, as I know Ella Grasso, our Secretary of State, does not need any introduction to the citizens of Connecticut. We are very honored to have her with us today. And, if you don't mind my referring to you as "Ella" ... I find it hard to call you Mrs. Grasso ... Ella happens to be a really grand lady, a grand lady in the true sense of the word. We are very honored to have her with us today. She is our Secretary of State, but she is not here in that capacity today. Ella is here because she has been carrying the torch for Rehabilitation for many years in the Legislature, in an Administrative capacity. As an architect of Connecticut's model statute in the field of Mental Retardation, the pattern she helped establish, as Governor Dempsey pointed out, has set an example for other states. She also helped to spark Federal legislation. She is widely known as a friend of the handicapped and I think that's a very important thing. Many people talk but they do nothing about it. As a private citizen, she is chairman of the Connecticut Cystic Fibrosis Association, and was recently honored by that association at a testimonial dinner. Her devotion to rehabilitation, the mentally and physically handicapped, is well known to all of you. So, it is really a very great honor and privilege to present to you, the Honorable Ella T. Grasso.

Honorable Ella Grasso: Thank you very much, Joe, Commissioner, Boss. And if you wonder why I say that, it is because Cy Flanders, whom you all know and love, represents, to my mind, truly vocational rehabilitation at its best. I know from personal experience how he took a brash young graduate who knew it all, and turned her into a loving, devoted, public servant for whom working for the people has been the greatest gift that can ever be given. Cy Flanders was my first boss. I worked for him and Joe Dyer in the Employment Service long ago and far away. Cy was the manager of the Hartford Office, and in those days if an interviewer behaved badly, the punishment was "to put them on the desk." And I just want to tell you that it was pleasure to personally greet every worker who came to Connecticut from any area and happened to stop at the Hartford Office. It was truly a great education, one that made an impression forever. Cy's compassion, his love and his dedication, I think, typifies all of his efforts that we are gathered here today to discuss and to define. I find that my task certainly isn't easy because the Governor has put into perspective all of those things to which we aspire. He has talked about that great and wonderful Connecticut tradition of citizens and their government, of men and women, working together in a common effort toward common goals. He has spoken of this wonderful and remarkable partnership among citizens, private organizations and the public sector. For instance, by teaching each other we have been able to bring rehabilitation to the present level of service and achievement in fulfilling our responsibility, each to the other, in defining and expressing our concern for our fellow man and our deep and abiding belief in the value of the individual, in the essential dignity of man. Earlier this morning I stopped for a little while to talk with Jim Peters, who told me about the tremendous advances that had been made in all of the State involvements in the area of vocational rehabilitation. I told him a Bible story that I had once read where you must turn your light to the world and certainly all of us who make up the community of Connecticut need to learn more about what the State itself has done from the time in 1939 when it was simply a Bureau of Vocational Rehabilitation. Now we have a Division with many varied and involved responsibilities. Going through all of this is the deep and essential link with private individuals and private organizations. We've come a long way from that day in 1816 when Services for the Deaf was first established here in Hartford under Dr. Cogswell; interestingly enough, a State grant was secured and then 20 years later when Services for the Blind were instituted a new program developed here. Always we have found that there has been a sense of direction from private organizations and that as they have set the stage, they have endeavored to define this problem to the public and citizens through the instrumentality of their government. I think some of the most exciting dramatic hours of my life have been spent here in this very room, when an organization called the Parents and Friends of the Mentally Retarded would come and pursue the education of the legislators and instruct us as to our moral obligations and the new horizons that were available, so that people who had handicaps might learn to live lives of decency, responsibility, of love and fulfillment close to the families which loved them and cherished them, close to the community in which they lived. And the work of this organization resulted in the formation of our own Department of Mental Retardation. Just as the Child Welfare Association resulted in the establishment of the Welfare Department in the State of Connecticut. Not only has it been in this area that we have gained the guidance, the cooperation, the support, the assistance of private organizations. We have founded numerous task forces, which Governor Dempsey referred to earlier, whether they were the task forces of environmental problems, such as air pollution, water pollution, open spaces, or whether they were in the areas of human concern which we have defined in the programs that we have established in Mental Health and in Mental Retardation. Now, here with this new Council, we have the opportunity to examine the magnitude of the problem, to determine what we are doing for all of those people who are handicapped and are in need of our assistance, to find out whether we are doing too much, if this is possible, or whether we are doing too little. Mary Switzer calls all of our Rehabilitation efforts an Act of

Faith. It is more than an Act of Faith. It is an Act of Hope, of restoring to useful productive lives and essential dignity all of the frustrated, unable to improve their role in society, to work, to live, to find fulfillment. Those of you in the field who have been so busy know of the frustrations and difficulties that you encounter. Sometimes the road is too long, sometimes the night is too dark.

As I was coming to work one morning, feeling very sorry for myself, I watched a man in the park who had a walker. He was standing by one of the sidewalks. The traffic was heavy and I was slowed down. I watched him and he was so concerned and was so disturbed. He wiped his hands on his pants, looked again and took one step forward, stopped, wiped his hands again, and I thought, "My God, he's never going to make it." So I stopped the car, went over to him and said "You know, I've been watching you and you are doing such a wonderful job." He wiped his hands on his pants again and took off across the park on his way, while I went back to the Capitol feeling a warm glow of accomplishment. The I said to myself "You big oaf. You think you are Lady Bountiful. How do you suppose that man acquired that walker? How do you think that he even got to the park? What do you know of the difficulty that he had encountered? What was the accident that made it impossible for him to walk? What kind of help was he given? Was there so much help from so many sources that you could not begin to sort it out, or was one organization assuming the responsibility for him? Did they and other people become involved because obviously they could do it so much better? They and they alone could help him. Or was this truly a marriage of true minds where every agency of possible service to him was called in for the rehabilitation effort? They were able to define the magnitude of his problem, help him solve it, and make the contribution that was so essential and so important. And of course, I didn't have the answer to all of that, because that is why the Council is here. That is why you have been called in today; that is why it is necessary to marshall all of the resources of those of you who are experts in the field, all of you who help to carry the word to the people, all of you who represent private organizations and the tremendous bridge to the community that this represents;, those of you who serve as servants of the people, as instruments of government. That is the task which is before you and that is the task which you will define today. We have come far from those days in 1816 when the first agency was established, when the government first became involved. So, you will prepare for us a blueprint for action, mindful of the blueprint that associations and the council of Mental Retardation prepared, entitled "Miles to Go". Of course, we have miles to go in every area. So, every particle of constructive energy can be the atom of encouragment that can restore usefulness and bring relief. Statewide Planning Project and the Statewide Planning Council were given the overall task of defining our objective for determining the permanent and continuing cooperation that can and must exist if we are to give maximum service to all disabled people; and I know that their first job is going to take the deadline of 1975 and advance it ever closer so that in the next session of the General Assembly, we will begin to see the positive achievements of the work which they have done, and will be able to do, not only in the education of the legislature, but also in the education of all the people, so that everyone understands what rehabilitation endeavors to accomplish, and all of the tremendous areas in which the public is involved.

All people want jobs, responsibility, -- want to be responsible and respected individuals; want self-esteem and financial dignity. One little girl said to me one day, "Everybody wants to be somebody." The rehabilitated person has discovered a new reservoir of independence, and an understanding of the efforts that have been made to him, through him, and with him. I hope that this hearing you are conducting today will find a good reception, not only in the State Capitol, but throughout the State, as your efforts toward involvement increase. And, of course, it is my fond hope, as was expressed by Governor Dempsey, that the work of the Planning Council will find expression in measures of service and responsibility that have been, heretofore, undreamed of.

There is a small quotation which I would like to leave with you who have made so many great and gallant contributions, because I know what you have done. You have been the dreamers of dreams, and you have been the seekers of truth, and you have been given direction in the work that you have accomplished. I think that this quotation applies to you ... "To leave the world a little better ... better by a healthy child, a garden path, or a redeemed social condition; to know that even one life has been easier because you have lived" ... to succeed ... And this success is yours. Thank you.

Mr. Ress: Thank you very much, Ella. As I have said before, you are a great lady ... really wonderful.

I asked Dr. Sanders, who has been the Commissioner of Education since 1956, to introduce some of the people who have been doing the legwork in connection with this Vocational Rehabilitation planning.

Commissioner Sanders: Thank you, Mr. Ress. It is a pleasure to come here at the invitation of Mr. Joseph Ress, the agressive and vigorous Chairman of the Council on Vocational Rehabilitation Services, which was founded in 1965, when the Federal Assembly made the Bureau of Vocational Rehabilitation of the State Department of Education into a Division, and also to hear the eloquent keynote address of our most distinguished Secretary of State. As you know, the Division of Vocational Rehabilitation is a division of the State Department of Education. I should like to introduce to you members of that Division. Dr. James Peters II is the Division Director. He has been head of this organization since 1956, when he first came to the State of Connecticut. Mr. Joseph Marra is the Chief of the Bureau of Rehabilitation Services; Mr. Robert Bain, Chief of the Bureau of Community and Institutional Services; Dr. Frederick Novis, Chief of the Bureau of Disability Determination.

I would like to introduce to you the staff of this Planning Project. The Statewide Planning Project is funded by the U.S. Office of Vocational Rehabilitation. Related to the Division in some ways, it is also independent, so that it may make an objective study. The Project staff, shall we say, is really working for the Council on Vocational Rehabilitation, which is made up of citizens who are interested and who represent all of you -- the people of the State -- directly.

The Project Director is Dr. Wesley C. Westman. Mr. Frank Grella is the Research Planning Director and Assistant Project Director. Mrs. Helen Hathway is Publications Associate; Mrs. Donna Friedeberg, Research Analyst; and Mrs. Rita Langevin, Secretary. Now,the members of the panel who are here this morning are known to many of you. I will ask each one to rise so that all of you can see them. This is Mr. Cyrus Flanders, State Labor Department, Executive Secretary of the Governor's Committee on Employment of the Handicapped; and Mr. H. Kenneth McCollam, Director of the Board of Education for Services of the Blind; and Miss Ann Switzer, on my right. Miss Switzer is Executive Director of the Association for Retarded Children. Mr. Arthur Dubrow is from the State Office of Mental Retardation, and Dr. George Sanborn is from our State Office of Departmental Planning, State Department of Education.

Joe, I will turn this back to you and you can get started. Thank you very much.

SUMMARY OF PRESENTATION BY J. BERNARD GATES, EXECUTIVE DIRECTOR, CONNECTICUT PRISON ASSOCIATION, AND CHAIRMAN, COUNCIL OF CORRECTION, STATE DEPARTMENT OF CORRECTION.

The report of the Division of Vocational Rehabilitation in the Digest of Connecticut Administrative Reports to the Governor 1966 - 1967, states, "The mission of the rehabilitation program is undergoing certain changes and extension because of its concern with urban poverty. Whereas in the past the rehabilitation effort was concerned with returning to useful work and self-support those whose poverty was caused by some physical or mental disability which set them apart from others, it is now also concerned with poverty caused by sensory and perceptual deprivation through poor housing, inferior education, job discrimination, minimum access to cultural stimulation, feelings of alienation, rejection, and isolation from the mainstream of society. Such sociological and psychological patterns blunt sensory stimuli and color perceptions."

Of the various segments of Connecticut society which the above definition describes, one of the largest groups would include many of the prisoners released from prisons, reformatories, and jails, and some of those men and women placed on probation by the courts. Some rehabilitation, vocational and otherwise, is possible in the institutions. Institutional treatment and training programs are being improved. There remains great need, however, for community-based vocational rehabilitation programs for the released prisoner, particularly during the immediate post-release period.

I am certain that other agencies will support our agency in recognizing the importance of the limited services which the Division of Vocational Rehabilitation has found it possible to provide the jails during the past few years. In addition, we have found invaluable the vocational rehabilitation services from the rehabilitation centers. In many cases, were it not for these programs, we would have had no place to turn for needed medical, psychiatric, and other vocational rehabilitation services necessary to the employment of released prisoners and their adjustment to community reponsibility.

It would appear that continuing, increasing, and improving these services will be important during the next few years. The State's increasing population, the importance of community-based programs which have been emphasized in the President's Crime Commission Report, the treatment and training program necessary to facilitate the provisions of the State's new narcotics act, and the highly probably court decision, concerning those who are currently considered to be alcoholic offenders, indicate that the need for vocational rehabilitation services will be immeasurably increased in the next few years.

The State of Connecticut is now inaugurating a new Department of Correction. This central and coordinated program will undoubtedly develop additional and improved vocational training programs in the institutions. It would appear important that, in conjunction with this institutional program which will emphasize the correctional process, there also be available to many of the men and women being released from these institutions the type of community-based services which only Vocational Rehabilitation can provide.

Question from Arthur DuBrow: For future requirements, I think it is important to have some idea as to numbers of potential rehabilitants. Can you estimate (I know it is hard to do), let's say, over a year's time, how many people released from correctional institutions -- including narcotics addicts, alcoholics, etc. -- would you guess, might be potential candidates for rehabilitation?

Answer: I think this would be a guess, as any physical information is absolutely impossible today. We're almost staggered as to what may be the impact of the new narcotic law. Certainly, in the neighborhood of 50% of all jail population is in need of treatment for various things, and, of course, where alcoholism is concerned, it is difficult to give a figure because of the numbers that go in and out of our jails in a year's time. My feeling would be a figure of 2,700 a year whom we provide direct service to. This year we will place approximately 1,200 on full-time employment. Certainly, the number in reformatories and jails alone is in the neighborhood of 500 a year, with some type of community-based treatment which, I believe, would come within this definition. And the number could be twice as many as that, according to the particular type of inmate you have coming out.

Question from Cy Flanders: I would like to ask one little question. What would be your idea of community-based services? Would that be half-way houses, or what?

Answer: I think there are many services involved here, and I do not mean to imply, this morning, that all services should be a direct responsibility of Vocational Rehabilitation, by any means. What I am urging is a cooperative program; such as the department itself, half-way houses, guidance, counseling, psychiatric evaluation. The physical needs of men who have no money should be taken care of. Since McCook Hospital and Jones Home are under a different administration, we have to find a way to care for these people while they are under such treatment. There's no place in Hartford for the unattached male. The Salvation Army does not have enough facilities. I think this is part of an overall picture. Half-way houses, private agencies, educational agencies, all should be part of one package, and what I am going to urge is that we all become part of a single program.

Question from Cy Flanders:	And that would include placement, also?
Answer:	That's right; we've had unusually good service from the Connecticut Employment Service. They were able to solve many of our problems, but I think I must say, in all sincerity, that this is only a beginning.
Question from H. Kenneth McCollam:	In the institutional training of an individual, would you plan to coordinate that with the Vocational Rehabilitation agency at this time, so that it would be joint planning on your part as well as that of the Rehabilitation Division?
Answer:	I think there is no question about that. I cannot speak for Mr. McDougal, although I had something to so with his coming to Connecticut. I studied his program for the State from which he came, before our Council recommended him. Great emphasis is placed on cooperation; and my belief is -- and I know that his is the same -- that a program has to begin the day that a man is sent to the institution, and has to be coordinated with a community-based program when he is released. It is an ongoing program which, once begun, does not end until the day he is able to assume complete responsibility for himself in the community.

TESTIMONY OF MAURICE MYRUN, PRESIDENT OF THE CEREBRAL PALSY ASSOCIATION OF HARTFORD

If vocational rehabilitation for an individual with a single handicap is a major task, how much more difficult is the job of rehabilitating a person who suffers from a host of handicaps? That is what we face when we make plans to help the cerebral palsied become productive, participating members of society. If these plans are to be carried out successfully, then not one, but a team of professionally trained experts, must be involved in diagnosis, treatment, care, and counseling, from infancy through adolescence and adulthood.

Some steps have been adopted in the past twenty years. A survey was taken in 1951. Educational facilities are being made available. Some C.P.'s have received therapy; some are receiving therapy. Yet, with the best of intentions, not nearly enough is being done to ensure the realization of their full potential, vocational or otherwise.

Various studies point out that time is of prime importance in detecting and treating cerebral palsy. The earlier the diagnosis, the earlier the treatment, the greater the likelihood of successfully overcoming the multiple handicaps of this disorder.

We need centers for diagnosis and treatment, staffed with pediatricians, orthopedists, neurologists, physiatrists, psychiatrists, psychologists, audiologists, opthalmologists, and therapists.

Counseling services should be made available, at least until C.P. children reach the age of adolescence. As for the C.P.'s themselves, they should have the services of a rehabilitation counselor throughout their school years. This counselor, functioning as part of the school staff, should be available from the earliest grades of elementary school right through high school. We well know the importance to the physically handicapped of the earliest possible vocational training and planning. Counselors should be recruited to work with the school, children, parents, and the community, on a well-planned, well-coordinated, continuous basis. Provisions should be made for therapy -- physical, occupational, and speech -- with a view toward the C.P. attaining his maximum degree of independence, and retaining it. For this, he will need such therapy for a lifetime so that he may contribute effectively to society.

At the same time, these young men and women need the proper facilities within which to learn to work and to develop their vocational potential, guided by vocational counselors specifically qualified in the field of cerebral palsy. The vocational counselor should be able to determine whether a particular client can enter into competitive work. It may be that the client cannot compete. In that case, his rehabilitation may be considered successful as long as he attains his fullest capability; accomplishing what he can; earning what he can. His right to a sense of worth must be recognized, as well as that of those not so handicapped.

In completing the picture, we must consider housing facilities in the mainstream of community life, where the adult C.P. may live, either on a temporary or permanent basis, where he may socialize with others, enjoy hobbies, and from which he may have easy access to work, school, and recreation.

Questions from Ann Switzer: What are the major breakdowns in your services? In what ways can vocational rehabilitation help?

Mr. Myrum: There are so many ways. First, you ask me where we find a breakdown. Our breakdown occurs when there is a lack of continuity of service. I will get back to your next question at the end. We find that in treating the cerebral palsied, a certain amount is done until a certain age is reached; say, through school. And then what happens to the individual after that? We feel, well, we have done something. What we have done is enough. There is no pattern that follows an individual throughout his life so that he may receive whatever services necessary to make him useful. We find, so many times when we attack a problem, that we are equally guilty with the others. We do it in a fairly haphazard fashion. We take care of the patient for a short period of time. We come back to it later, but there is not that continuous flow of services in the field that would result in his being a whole person. Now, as far as cooperating with all the other agencies, and, of course, that is the ultimate to be desired, we would very much like to have a central location so that all services could be drawn together at one point for all of the handicapped. I do not speak of the cerebral palsied alone (I speak for all the handicapped), where all of them may receive the benefit of diagnosis and treatment. I think we need a central place, of some kind, that is effective and can be reached by all of us.

TESTIMONY OF JACK SAGE, PLANNING ASSOCIATE OF THE COMMUNITY COUNCIL OF GREATER NEW HAVEN

Vocational rehabilitation is an investment in human resources which aims to eliminate under-employed, undeveloped human beings through the utilization of a broad range of training programs and supportive services. The Statewide Planning Project for Vocational Rehabilitation Services is in the final stages of preparing a report due to be completed in October which is designed to show how this objective can be achieved with maximum efficiency and effectiveness, on both a regional and State basis.

I am a member of the New Haven Regional Planning Committee, and wish to take this opportunity to urge your support of the forthcoming report. A great deal of professional and citizen time is being contributed to this study, and I think its final product will be worthy of your support. In the interim before the report is completed, I wish to call your attention to three areas of need:

1. Addiction to both alcohol and drugs is increasing dramatically. At the same time, new techniques in treatment and rehabilitation are being developed. This is one area where more funds will need to be allocated.
2. The time has come to extend traditional vocational rehabilitation services available for the physically handicapped and mentally disturbed, to the culturally and socially deprived populations of the slum areas of our cities.
3. There is a need for more planning and coordination of existing programs both on a regional and State basis. Funds should be made available to the Division of Vocational Rehabilitation to fulfill this need.

I would urge that the State seek every Federal dollar that can be obtained by matching 25% of State funds with 75% of Federal funds. The failure to obtain every available dollar will result in under-employed, undeveloped human beings -- an unpardonable waste of human resources.

Question from
Arthur DuBrow: Why do you feel that agency coordination and planning is the ongoing function of the DVR?

Answer: The Division has a structure that is both statewide and regional. In the New Haven region we have been concerned, as we have been meeting in the New Haven Regional Planning Group, about the lack of communication among agencies which are involved in rehabilitation services, and I feel that the Division, which is statewide, could serve this function of coordination and ongoing communication with agencies that are actually involved.

TESTIMONY OF SHOLOM BLOOM, EXECUTIVE SECRETARY, COMMISSION ON SERVICES FOR ELDERLY PERSONS

Introduction:

Rehabilitation means many things to different people, and by definition in its broadest terms, conveys "a quality of life of self-help for the handicapped". Rehabilitation is the responsibility of many diverse public and voluntary programs. Exact statistics of elderly citizens in our State who are receiving or require rehabilitation services in the various categories of rehabilitation is difficult to ascertain. It is our impression that the elderly represent an under-served grouping, and that not much is done for the elderly person, especially in the area of vocational rehabilitation. Vocational rehabilitation is a must for men, and increasingly will be for women. Work is the major contribution a person makes toward his well-being and personal happiness. We have also found that the plight of the handicapped elderly citizens is not very well understood nor brought to the attention of the public. Furthermore, I feel that part of the problem which relates to State Government is that no part of State Government can begin to provide and deliver services without total coordination of State Government, starting with topmost levels.

Recommendations:

I urge the State Planning Council of the Vocational Rehabilitation Services adopt the following recommendations:

1. Establishment of closer liaison between the Division of Vocational Rehabilitation and the Commission on Services for Elderly Persons, where both agencies will provide staff for these responsibilities.

Staff would then develop a written statement of coordination, covering areas of service to elderly, staff training, and the like.

2. Request should be made to the Legislature to provide funds for a Senior Corps such as that enacted by the State Legislature in 1967 Public Act 662 (Public House Bill #3180, page 1751, General Assembly 1967); however, there was no appropriation made. I will file a copy of this Act with your Chairman.

3. Development of informational teams to reach out into the State, providing public information or rehabilitation services to all age groups, as well as the elderly. Also, development of advisory committee on aging, to include participation by the elderly themselves, for each regional rehabilitation center.

4. Enactment of a law providing for informational and referral officer at the municipal level, such as was presented to the Legislature under House Bill #2841, by Representative Mrs. Ruth Truex, 23rd District, Wethersfield. Bill not passed. I will file a copy with your Chairman.

5. Support of the transportation model of the Commission on Services for Elderly Persons' plan for "Dial-a-Ride Program", copies of which will be filed with your Chairman.

6. Effectuation of model for State agency coordination and delivery of services to the entire State, a copy of which is attached.

Question from Arn Switzer: Mr. Bloom, I am interested in the Senior Service Corps Bill; I am very much involved. I am aware that no money is appropriated. What is your feeling about the Demonstration Program? I believe there have been three very successful ones in the State of Connecticut, called Foster-Grandparents Programs. Do you feel that, when these Demonstration Programs are over, groups might follow through, using Senior Service Corps, implementing a statewide planning with State money?

Answer: The Foster Grandparents Program, which was funded through a contract, by the Office of Economic Opportunity, was cut off, and Governor Dempsey had to make an emergency appropriation. My feeling is that we move to quadruple Foster Grandparents Programs in the whole State of Connecticut, first, from a rehabilitation standpoint, from a morale standpoint, and, probably more important, because we have a contribution to make to the sick, the abandoned, the neglected, and the mentally ill child. Theoretically, I could stand here for a long time, quoting many examples to show progress that has been made, proving this statement, and my feeling is that the State of Connecticut would, rather than pay lip-service to the elderly, do better to provide a mechanism for the elderly to work and make a contribution to the Senior Service Corps. When Foster Grandparents Programs come to an end, what happens after that? As a Statewide Council, if one is looking into the future, what are your recommendations?

Question from Arthur DuBrow: Don't you think that somebody, maybe your commission, should do something with business and industry; should break down an arbitrary feeling about the end of a person's usefulness at a stipulated age? Otherwise, you could talk all day about employment and it is never going to happen.

Answer: We do have a committee which includes this; and the whole aspect is so terribly important. Connecticut has had great experience, with Scovill Manufacturing Company, which is a model for State coordination and a prototype. We have to experiment in the State, with the elderly, toward the "art of retirement". (I don't want to elaborate on the material which I have presented as part of a model for State coordination to speed this whole process up and delivery services to the handicapped, to the elderly person.)

Question from Cy Flanders: What do you call "elderly"? What is the age limit?

Answer: Cy, I am sorry that you asked me that question. Aging is a process that will be different for all of you in the audience. The statutory requirement of the United States Department of Labor, again, has another definition. Some programs here in Connecticut, interestingly enough, have no set age. For the purpose of argument, we could use Social Security -- ages 62 to 65 -- or how about 60 to 65? Being aged is when you are thrust aside on a scrap heap, unavailable for a job, or you are put into a convalescent home.

SUMMARY OF TESTIMONY OF ARNOLD LAWRENCE, A.I.A., ARCHITECT

1. If convenient parking is not provided and properly identified for the handicapped, State aid, or State-administered Federal aid should be denied.
2. Furnish expanded physical medicine and rehabilitation programs by making use of the network of qualified convalescent homes recently built throughout the State by offering financial aid for construction of adequate space for the program and operation of the program.
3. Develop a combined housing and workshop for the handicapped, so they may live and work in the same complex when minimum health care is necessary and transportation is a problem.

TESTIMONY OF SAM WILSON, DIRECTOR OF ECONOMIC DEVELOPMENT AND EMPLOYMENT, URBAN LEAGUE

Although vocational rehabilitation services in the Negro community are obviously very limited and, in many instances, non-existent, superficial barriers have tended to be more of a handicap in terms of employment and training opportunities than the need for rehabilitation services, per se.

Finding gainful and suitable employment is quite a problem for any person who has suffered from some physical or mental disorder. However, the problem is more acute as it relates to the Negro or minority group member in the community. Some specific examples of these superficial handicaps may help to shed light on the problem. First of all, it is a handicap just to reside in the ghetto and to be stigmatized as something other than a human being. The average ghetto resident does not fit the mold or meet the standards of acceptability which white America has created. Secondly, this isolation from the main stream of American life actually causes many ghetto residents to believe that perhaps they are inferior. Therefore, they are reluctant about applying for many job opportunities. Whenever they can muster the courage to apply for a job, they are often intimidated by those personnel interviewers who pass on their feelings of prejudice, failing to talk to individuals with respect, or talking "down" to them.

This rejection often frightens the black person so much, that he becomes accustomed to expecting failure, no matter what his abilities or skills may be. Employment testing, too, frightens him, for he knows that, in most instances, the test will be the sole criterion of whether he will be accepted as an employe or rejected. Furthermore, he knows that he is expected to fail, and therefore, usually does.

Complicating this deplorable situation, are the many "normal" arrests in the black community, for breach of peace, loitering, and the like, that militate against these people finding suitable employment. Oftentimes, such arrests occur when the individuals are juveniles; and, while they may have conformed to "being good" and "keeping their noses clean" for several years, many employers still find that these arrests are reason enough not to employ the individuals. Then, of course, you know the plight of those who have been to a reformatory or other juvenile detention home. Their chances are usually nil, or very slim, at best.

Finally, mention should be made of the problem of work attitudes and responsibility, as it relates to the ghetto Negro. It is my personal opinion that the Negro does not stay off a job or come late, or fail to call his superior when he must stay out because he does not want to work. He does so, because, in many instances, he feels that no one cares what he does, and in other instances, because he does not know any better. How can a person assume responsibility when he has never had to be responsible? Attitudes are learned from one's culture. Therefore, the Negro has, since slavery, been taught and conditioned to exemplify a pattern of behavior totally different from that of the majority society.

In summary, there is a need for vocational rehabilitation services in the Negro community because people there are no different from other people, in respect to their needs. They suffer from both physical and mental disorders which require some understanding, proper care, adequate facilities, and lasting patience. But, overriding these needs, is the ultimate need for an awareness of conditions of superficial handicap that have traditionally been more of a burden to the Negro individual than either physical or mental impairments. To change these conditions, this Planning Council, and all other concerned individuals and agencies must see that laws are passed to protect individuals against unjust treatment totally related and unique to their environment and way of life. These laws, if passed, must be vigorously enforced, and not filed away to collect dust. Finally, the services of vocational rehabilitation must be made known to the Negro.

TESTIMONY OF RALPH ADAMS, PRESIDENT OF ALUMNI ASSOCIATION, OAK HILL SCHOOL

The State Board of Education and Services for the Blind has a tremendous task to perform, in that it helps in the needs of all the blind of this State, whether they are persons who went to school while they were blind, or became so after school age (but still in the years when they could and should work), or the older blind. Those of us who became blind early enough to attend school, -- specifically, the Oak Hill School, -- receive certain types of rehabilitation at that school which the State Board of Education and Services for the Blind should, perhaps, give to individuals who attend only public school, or who become blind after school age, but still as young adults. There seems to be a difference of opinion among members of the Alumni Association as to just how much influence the Board has in directing the program in the field of rehabilitation at Oak Hill School, or, for that matter, in any other area. Those who attend Oak Hill should not be required to take certain courses which the Board should offer to those who did not attend this school; and it is hoped that those who attend Oak Hill would have had enough good training that they would not ask that the Board repeat such a service for their benefit.

Mobility training is one area that has developed since World War II. This is a field in which both Oak Hill and the Board should offer training, the school as a requirement. It is our understanding that the Board, in the future, may give a course in homemaking. Many blind persons would be grateful for such training but, here again, we feel that those who attended Oak Hill should not be required or need to duplicate such training. Let me say that the reason for emphasizing that there should not be mandatory repetition of training given at Oak Hill is because we understand that, in at least one State, students who graduate from the school for the blind are required to take the courses offered by the rehabilitation center or no help is forthcoming. Such requirements show a lack of cooperation between the two agencies, and are a needless waste of time and money. We in the Alumni Association have been quite shocked to find that many of those who have been graduating from Oak Hill in the past few years cannot, and have not been taught to write their names. In the world of today, this is a necessity. If blind children attend public school, we urge that these children, as well as those who attend Oak Hill be required to learn how to write their names.

Some members of this Association feel that there should be a sheltered workshop. If such proposals are in future planning, this organization, as well as others, should be able to contribute constructive ideas and suggestions if the matter is presented so that members may discuss it in advance of stating a position.

Some stand operators have expressed a need for going over the stand program by the Board. Perhaps the Board could contact each stand operator, asking them, anonymously, to express ways of improving the program.

Many times, a blind person feels that something the Board is doing, or not doing, is unfair. We would like to see some type of a grievance system initiated so that when such things occur the individual may have an opportunity of discussing with the Board and a representative of the blind (not connected with the Board) the individual's grievance.

We hope that, in the future, many more blind persons will become gainfully employed. Most of our members feel that anyone earning less than the minimum wage is NOT gainfully employed. Most members feel that, once work has been obtained, they are stuck with it whether they really like it or not.

There will always be criticism of any agency such as the State Board of Education and Services for the Blind, or a school such as Oak Hill. Our criticism should be constructive.

Question from Mr. DuBrow: What is your feeling about the sheltered workshop working for integration of the blind with existing workshops?

Answer: I can't answer for that organization. But, my personal opinion is that I would rather see the blind integrated in a sheltered workshop. I think that it would be better for them. Of course, today Oak Hill School, itself, has many multiply-handicapped, and I am not too familiar with this area. This would go into a different type of rehabilitation, naturally.

Comment by H. Kenneth McCollam: I would like to comment briefly on some of Mr. Adam's suggestions. I think that they are very worthwhile and are suggestions which can be worked out, as time goes on. I would like to point out that the Connecticut Institute for the Blind is a private agency and not under any direct control of the Board of Education and Services for the Blind. Therefore, any influence the Board has over the Connecticut Institute is based on a cooperative relationship between the Institute and the Board. We (The Board of Education and Services for the Blind), cannot dictate curriculum or policies that relate to the school's program. We do, however, try to suggest, tactfully and diplomatically, areas of improvement in the curriculum and the inclusion of certain courses in the school's program which we believe would better coordinate the training which is being given at Oak Hill School. You spoke of mobility as a requirement. I think we are getting closer to a better cooperative relationship in that area, since the Connecticut Institute is now employing a mobility instructor trained in paraphetology at Boston College, following the same techniques that the mobility trainers on our staff are employing. This tends to cause a decrease in the amount of retraining in this area. I think that many of the things which you have suggested are very worthwhile, and you may assure the Alumni Association that the agency is ready and willing to communicate with them, if they will only make their views and options known. Thank you.

Comment by Ralph Adams: I will relay your message to the Alumni Association, and we would like to see some way in which the State agency could have more influence at the school. Perhaps the Alumni Association, itself, could put a little bit of pressure on the school to get some of the improvements that we all know are needed.

TESTIMONY OF BOB FOSS, EXECUTIVE DIRECTOR EMERITUS, NEWINGTON HOME FOR CRIPPLED CHILDREN

Mr. Chairman, members of the panel, I am very pleased to be here today. My name is Gregory Foss, better known as Bob, Executive Director Emeritus, the Newington Hospital for Crippled Children. I was very pleased to learn that the

Governor had appointed a Planning Council for Vocational Rehabilitation, and I am sure, because of what has been said here this morning, because of the interest of the panel, and the Governor's leadership, that something progressive will be forthcoming. I would like to say that I will be happy to serve on any committee where my experience of 22 years at Newington Hospital might be of some help. I can only cite a couple of examples from my experience. One young lad who had had poliomyelitis and was completely paralyzed on one side from head to toe, had reached a point where the medical profession could do nothing for him. I contacted Vocational Rehabilitation and they sent him to college, but, unfortunately, he flunked out, and then he was at home for several years. Mr. Chester, who was then head of State Rehabilitation, visited me one day, and I asked what had happened to so-and-so. He said, "That's a good question. I will make it my business to visit him, personally." He did this. This lad lived in Torrington on a third floor, and there he had been for three years, looking at the four walls. He was interested in accounting, so the State Rehabilitation financed his course in accounting. Then he graduated, and Mr. Chester came to me and said, "Now what do we do? Who will hire him?" So we did. He's been there ever since, is married, has a child, and is the happiest man in the world. Another case is that of a lad who had arthritis and was given a choice, through surgery, to stand or sit for the rest of his life. He chose to stand. We trained him in our Dental Department as a technician. He, too, is now married. It is an inspiration which shows that almost anyone can be helped, and I am sure that the final reports of the various committees which have been formed will do much good in fostering a program where all handicapped children and adults can be helped beyond what could be done for them medically. Thank you very much.

Question from
Ann Switzer: I have re-entered your two stories, Bob. There's an awful lot of good stuff here. You have taken on for rehabilitation, training, and employment, mentally handicapped people, too. Now I would like to ask you if you feel as you felt when you were the Administrator of Newington, -- whether your success was due to

the sheltered environment of your hospital, -- whether these are typical cases, -- or whether you think that the technique you used, with the full information you had on the candidate for rehabilitation and training, could work any place, -- or are we asking too much?

Answer: I think these techniques would work any place. They (the patients) are worked on medically and surgically and are discharged, and that's it. I think that much can be done in hospitals to foster a follow-through and see to it that they are referred to the proper agency where an ongoing program can be developed for these persons. Newington has helped them in a small way, but I am sure that much more can be done. There may be more jobs in their facility, now that they are expanding with new buildings. Maybe there could be a tie with the State and Newington. There could be facilities right there in certain areas.

TESTIMONY OF ALAN A. DUN, M.D., PRESIDENT, CONNECTICUT REHABILITATION ASSOCIATUON MEDICAL DIRECTOR, THE TRAVELERS INSURANCE COMPANY

The following comments reflect observations as a spokesman for the Connecticut Rehabilitation Association and are not intended to reflect the views of the Travelers Insurance Company or the insurance industry.

I Subject: Rehabilitation and the austerity program

The status of rehabilitation services in Connecticut, factors which may account for the existing situation, and some anticipated results of current conditions will be briefly outlined. Some conclusions seem justified.

A. The status of rehabilitation services in Connecticut:

1. It has been estimated that 68,000 Connecticut residents need rehabilitation services at the present time. The backlog of unserved citizens may reach 140,000 by 1975.

2. The current DVR staff includes approximately 60 counselors. The Harbridge House study (1966) in our State estimated that 120 counselors would be needed by 1970 to effectively administer the rehabilitation program.

3. DVR service funds were exhausted during the final portion of the third quarter of the current fiscal year, and facilities

providing rehabilitation services to DVR clients are not receiving any DVR payments.

4. Apparently, DVR has no funds to pay salaries of additional counselors.

B. Factors which may account for the current situation:

1. All Federal funds allocated to Connecticut for rehabilitation services have not been captured. Our legislators failed to obtain the following available Federal funds for rehabilitation services: $383,487 in 1968; $853,149 in 1969.

2. Monies designated for service funds in the DVR budget may have been utilized for salary adjustments, since we have no evidence that the General Fund was utilized for recent salary adjustments.

3. The current State austerity program is not conducive to consideration of additional appropriations for DVR rehabilitation services.

C. Some anticipated results of current conditions:

1. The backlog of unserved citizens in Connecticut in need of rehabilitation services may increase substantially, due to impaired quality of DVR services and limited ability to accept new clients.

2. Unserved Connecticut citizens needing rehabilitation services may increase the welfare roles.

3. DVR counselors cannot function effectively without service funds.

4. Lack of DVR service funds may create economic hardship for private rehabilitation facilities.

II Conclusions

A. The failure to take advantage of Federal funds allocated to Connecticut for rehabilitation services suggests an unrealistic appraisal of the need for rehabilitation services in Connecticut by our legislators.

B. The apparent use of DVR service funds to adjust salaries may have exhausted service funds and would seem to represent an unsound fiscal policy.

C. Providing substantial funds for DVR counselor salaries but no service funds appears to be an unproductive and wasteful use of tax dollars.

D. Any immediate savings which may result from reduced DVR counselors and services will probably be more than offset by the future expense to Connecticut taxpayers of the neglected citizens who now need and are unable to obtain adequate rehabilitation services.

TESTIMONY OF MONROE FEARING
MEMBER OF BOARD OF DIRECTORS OF NEW HORIZONS, INC.

My name is Monroe Fearing. I am a member of the Board of Directors of New Horizons, Incorporated, and I am very pleased to have this opportunity to offer testimony for this Statewide Planning Project. New Horizons, with a membership of over 400, and headquarters in New Britain, Connecticut, is a non-profit organization intended to serve the severely physically handicapped adult. New Horizons, of course, is interested in all phases of service to the disabled, such as health needs, physical and vocational rehabilitation, education, job training and work opportunities. However, New Horizons is vitally concerned with where the disabled live at present. In particular, these are individuals who have completed their physical rehabilitation but, because of the severity of their diabilities, are unable to return to society -- those who need some degree of assistance in performing their activities of daily living. Today, we can find members of this group living in the isolation of a private home, or, for the most part, in nursing homes invariably geared for the elderly. New Horizons believes the answer to this problem is the establishment of a home and center where severely physically handicapped adults can live and work together.

The New Horizons Home and Center would provide activities and opportunities for its residents. By activities, we mean assisting in the running of the Home and contributing to the organization. Activity also means work for pay. The New Horizons Home and Center will provide the opportunity to work. Any position in the operation of the home (office, dietary, purchasing, etc.) would be filled by residents whenever possible. Work done in the resident's room, such as bookkeeping, telephone service, typing, survey, research, etc., will also be possbile. There would be a large industrial area incorporated into the same building where the residents live. This large work area would provide space for light industry (assembly, inspection, sorting, etc.) that would be sub-contracted from factories and businesses in Connecticut. It is believed that such a workshop would provide the greatest opportunity to work for the greatest number of residents. The inclusion of living and working arears under one roof would eliminate the largest single obstacle in the path of the handicapped who desire employment: the obstacle of transportation.

Finally, we can add social, cultural, and local community activities to the opportunities that will be found in the New Horizons Home and Center. This is New Horizons' answer to this problem.

In conclusion, New Horizons would like to make two other suggestions that seem worthy of exploration in the area of where disabled people live: first, a half-way residence where those who have finished their rehabilitation might live, temporarily, as a test before returning as independent members of society; second, if we have low-rent apartments for the elderly and the low income or disadvantaged, why not then have apartments especially designed for the physically handicapped, where a live-in nurse and a few aides could give minimal assistance for the occupants of the residence?

The problem of creating facilities where the severely physically handicapped can live and work is, as Dr. Howard A. Rusk recently stated, "one of the greatest un-met needs in America today."

ELIZABETH M. STABLER, EXECUTIVE DIRECTOR
AID FOR RETARDED CHILDREN, INC.

Connecticut does a better job than most States for children and young people in trouble, but in a State with our resources there are still unmet needs of the kind we just can't afford.

Let's suppose you are just an ordinary family - loving, doing the best you can for your child, but he begins to do poorly in school. It makes no sense to him; he's a truant; he seems sullen, withdrawn, unhappy.

Yes, maybe you and your husband decide - he's just a teenager - he needs to get free of us, he's looking for his own values, but where do you find out for sure? Or he starts setting things on fire. What is this? How serious? What do we do?

It may be he's retarded, poor in academic subject, out of things with his peers. We get youngsters with a psychological report sent to our workshop from a Junior High Class that says - "This boy is belligerent, destructive, hates everyone, might need psychiatric help." We sit this boy down at an electric polishing machine in the workshop and all these symptoms disappear. Our youngster gets a paycheck; he feels like somebody, doing a job he is good at; he's cooperative, reliable and good humored. Is it the boy that's wrong or the school program?

If a culturally and financially deprived youngster, retarded only in academic subjects that seem irrelevant to him, had vocational training and help from a counselor who knows about good work habits and what he needs to get a job, he'd stay in school. But where is the vocational training? Where are the work experience programs? Where is the counseling for this confused youngster? The Technical schools have tightened requirements so he can't get in there. Psychiatric help is often months or years away with not enough clinics available.

We have proved that a work experience often makes psychiatric help unnecessary. With more financial help and leadership from the legislators we could prove that work is therapy and the chance to start learning how to be productive often the answer for difficult unhappy children. In an affluent society we give them too much and ask too little of them; or we give them a bare living only and then ask them to spend years "going to school". They are bored with French and Algebra - even adding Swahili doesn't help because they want to start "learning a job so they can be somebody".

We're a long way, in Connecticut, from the small village where every child saw every job and his place in the community. Now if you have a disability - physical, emotional or cultural - there are literally thousands of jobs in a complicated industrial set up that makes choosing a life work hard on normal youngsters.

A handicapped child needs skilled counseling, more vocational opportunities in schools, more vocational orientation in guidance departments and psychiatric clinics, more work experiences, more social growth through suitable personal adjustment training and recreation - and more pressure on the State Vocational Schools to provide appropriate courses for the handicapped youngster.

It is a wonderful State - Connecticut - and it has proved that the handicapped youngster can be a productive citizen in many different experiments. Now we know, so let's act on our knowledge and give the Division the support it needs to give these opportunities to all disabled youngsters. Then they will be paying taxes, and more important they'll be part of the mainstream of the very pleasant and productive working world that we in Connecticut take for granted for ourselves. Let us at least plan for a vocational evaluation of every disabled child so that we know what he needs and then make sure he gets it.

We also need, after this diagnosis and evaluation, treatment and training, vocational counseling and placement.

The need of all children who need help cannot be met because finances run out, and personnel is overburdened. A coordinated push from the whole community could make a good life possible for all of them. They can't fight for themselves.

I am reminded of a dinner with a retarded young man from our Workshop and his very dominating father. The waiter asked me what I wanted and then the father. He leaned over and said, "And now, young man, what would you like?" The boy looked around at all of us and said, "He thinks I'm real."

They are real, and their needs can be met. We've proved this for some. Now we want to expand our services to help more of them, with your help.

We want the Burueau of Education and the Division of Vocational Rehabilitation to work with other agencies so that handicapped children may become as independent and self-sufficient as is possible. This can be done if you support programs that will increase qualified personnel and give them modern equipment and techniques.

Question from Cy Flanders: I would like to ask one question. Would you think that the Rehabilitation Center should be used much more for the extremely disadvantaged groups that were spoken about this morning?

Answer by Dr. Stabler: Yes, I believe we have a commitment to this kind of thing. All the techniques that we learn show that people grow when they are in the sort of situation where they are useful. We have a long background of showing that this is the way people grow and become valuable to themselves and other people, and it seems to me that this is what is wrong with many so-called "poverty programs"; that they have been artificially set up to that we haven't been able to give people the feeling that they are really going to continue to benefit when the money runs out. Now, that's the kind of thing that you can do. It seems to me that there is a real place here for us to use the things that we have learned about making people like themselves better, and therefore being able to cope with their lives.

Question from Cy Flanders: Is that regardlesss of whether they have a handicap or not -- I mean, physical or whatnot?

Answer: I feel that most of them have handicaps. They haven't had any of the kind of care -- physical or emotional or any other kind of care -- that most of our children take for granted. We have a commitment to a special group: the handicapped. But the emotionally handicapped cannot do anything with their lives, or they can be so retarded that they cannot do well in schools. I wish we had the money and the personnel to expand. I don't know if we do. We are swamped with the people to whom we are committed. We do a great deal for the people who test retarded. We test simply their ability to learn in a given situation, and our test means actually nothing to the person from Puerto Rico, or to one who has lived in a ghetto all of his life. The Wechsler test doesn't mean anything to him, so when we sit him down in work situations and give him something that he knows he can do, his test comes out quite differently. I wish we had a social I.Q. test rather than the one we have, because some of these people would test better than many of the intellectuals whom I know.

TESTIMONY OF ROBERT DAVIS
HARTFORD HUMAN RELATIONS DEPARTMENT

In an effort to reach the "hardcore" disadvantaged unemployed individual, a more affirmative action program must be stressed from a rehabilitative standpoint.

It is alarming to note, here in Connecticut, a steady increase in the number of "hardcore" unemployable disadvantaged persons, moving in a cycle from one agency to another, from one employer to another, and turned away.

What is meant by "hardcore"? My definition for "hardcore" is that individual who is disadvantaged by a deep-seated anxiety with respect to internal needs, felt needs, for personal, academic achievement and vocational prestige, exhibiting signs of acute personality maladjustment.

Many, if not all, of these "hardcore" individuals are maladjusted, largely due to the acute, frustrating vicissitudes and insecurities of daily living, the daily anticipation and realization of actual occurrence of failure in the world of education and vocation.

The maladjusted "hardcore" individual cannot help but respond to the inner tensions engendered by conflict between the development of self-confidence through "doing, and becoming a functional part of society. Such a person is further maladjusted since he responds to feelings of shame and rejection of family background and ties, resulting in feelings of guilt and anxiety. This maladjusted individual, because of his inferior social status -- academically and vocationally zero -- becomes personally and psychologically demoralized.

From a rehabilitative standpoint, perhaps we can now readjust our thinking to the problems that beset the disadvantaged, "maladjusted" individual. Connecticut is full of agencies designed to relieve our poverty plight, agencies that are more concerned with developing social policies that are person-oriented rather than system-oriented. The solution to the problem of the "hardcore" maladjusted is not to change his attitudes, motives, or skills completely or totally, but, rather, to change the opportunity structure that confronts him. In employment, stress has been placed on improving the individual's education and skills to bring him up to the demands of the labor market. Meanwhile, he is living on a $35-$45 stipend, starving and struggling to make ends meet, and has just plain "thrown in the towel" (or a brick). Rather than change or modify employment qualifications to fit the capacities and skills of the worker... It seems the panacea for the problem is not to tailor this "maladjusted" disadvantaged person to the system, but rather to modify the system to tailor the skills and capacity of the "maladjusted".

The symptoms of the hardcore unemployable are disabling. These persons are handicapped because of a variety of deficiencies: alcoholism, drug addition, criminal records, speech and language problems, social conditions, migratory conditionings, lack of education, and even more serious, emotional and psychological problems, resulting possibly in schizophrenia, male and female prostitution, serious neurotic disorders, and all the various complications.

1. It is suggested that the Division of Vocational Rehabilitation begin now to analyze and evaluate the employment situation in a given area and develop new attitudes through a process of remedial type employment in a workshop setting.
2. The total person has to be served: social, physical, and emotional needs, from a rehabilitative standpoint. This requires inter-agency understanding, a unified coordination concerning the threefold problems of an individual. The time element for declaring eligibility for rehabilitation is unrealistic and detrimental to the "hardcore" -- for his needs require "now" services.

Question from Ann Switzer: I would like to make an observation. I think -- maybe not for the first time -- but I think that you have emphasized two or three things here which, obviously, we thought about... I wonder now if you feel... You mention some new type of experiment with the Bureau of Vocational Rehabilitation and other agencies working with the "hardcore", taking the lead... Do you feel that the present Vocational Rehabilitation Services... From where you sit with your job and your own experience in the field, do you think that they have made any dent at all on the "hardcore", as you see it?

Answer: I have been in Hartford one year as Project Director, Employment Agency. I have had the occasion to refer three people for Rehabilitation Services and, as I mentioned before, it has taken these three people an almost indefinite time before services were administered to declare these persons eligible. This is on the State as well as the city level. These individuals were definitely "hardcore" individuals who, through no services that were administered by other agencies (job orientation, work adjustment) were helped. But a vocational rehabilitation service could perhaps have helped this man. At the time he waited for services, this man was unemployed and, as a result, he returned to his old ways, such as alcoholism and personal social deprivation.

Question from Cy Flanders: Could I ask one more question? I remember talking to you when an employer was willing to hire a handicapped person with certain qualifications, and you made a real effort, through preachers, etc., to locate such a person, and you did, but, for one reason or another, the person did not show up for an interview. Without regard to that particular interview, what would you have done with that person? What would you suggest be done to follow up, so that maybe something could be done to help that individual?

Answer: I think there is need for some follow-up for individuals like this. You have to take into consideration the reasons for his now showing up for the job. There may be reasons... He may be afraid. He has been turned away so often that he thinks this is another such case. He should he followed up and asked why he did not show up for that job. The counselor must sit down and talk to this person, because he lacks work adjustment. He has attitudes that must be changed, and he has also concerned himself with the attitudes of the employer.

Question from Cy Flanders:

Who would do that follow-up? Would it be up to somebody in your agency to make a referral to somebody else to let them know the score?

Answer: Well, my agency is very inadequately staffed. I would have to use other agencies for follow-up. This is one aspect where Rehabilitation can follow up for us. Agencies can use Rehabilitation for this.

TESTIMONY OF ROBERT LACAMARA, M.D., MEDICAL DIRECTOR, CHILDREN'S SERVICES, NEW HAVEN AREA REHABILITATION CENTER

The citizens of Connecticut are fortunate to have very good rehabilitation services. However, from a practical standpoint, not all citizens are able to receive top quality services. One glaring deficiency is in the area of special education. Legislation has provided some funds for all communities to develop special education programs for handicapped students, either locally or regionally. Too often throughout Connecticut, the local community resorts to the easier method of sending a homebound teacher into the home, rather than planning carefully, locally, or with another school district, to develop a more effective group learning environment. Individual tutoring has its merit, but too many communities send a teacher (usually not one trained in special education) into the home and plan no further, implying, "Now we have complied with the minimum requirement of the law." But what about the needs of the handicapped student? Obviously, more funds and possibly new legislation is necessary for an effective statewide program.

Other areas of need for the handicapped pre-school and school age children of our State including the following:

More effective case finding: Too many handicapped citizens are not receiving services already provided within the state through lack of awareness of services and lack of awareness of the patient's needs by existing agencies.

More effective inter-agency cooperation: Lack of effective inter-agency coordination and planning of existing and new services, particularly at the patient level slows efficiency of services.

Increased funding: Lack of funds for the "in-between" citizen. Low income and upper income citizens have provisions through insurance and state funds. Those citizens falling in the "gray" areas of funding help find rehabilitation services very costly, and needed care may be unavailable on a financial basis or available only through sporadic gifts by interested private citizens and organizations.

Better qualified personnel: Though special education programs exist (training,or teachers, therapists, etc.) existing agencies are suffering from lack of personnel. Only one physical therapy school exists in Connecticut and no occupational therapy school.

More funds for services not directly related to therapy: For instance, funds may be available for therapies, but no insurance or third party payment is available for the case-finding social worker or the inter-agency coordinator.

More funds and personnel in quantity to provide the important services provided by developmental psychologists.

The need exists for continued planning, expenditure of money, and creative thinking if Connecticut is to retain its leadership in assisting its handicapped younger citizens to become more self-sufficient and responsible adults in our Connecticut communities.

Question from Maurice Myrun:	Do you know if the University of Connecticut has training for occupational therapists or physio-therapists?
Answer:	I know that there have been plans but I must say that I don't know if it has gotten to that point yet.

TESTIMONY OF ALICE P. IRWIN, TREASURER AND PRODUCTION MANAGER, HARTFORD ELEMENT COMPANY
(READ BY MRS. SOPHIE MYRUN, CHAIRMAN, HARTFORD REGIONAL COMMITTEE)

As Treasurer, Production Manager and Personnel Manager of the Hartford Element Company, a small "job-shop" type of manufacturing enterprise, I have had considerable experience in hiring, training, and evaluating many diverse types of handicapped individuals referred to us by various agencies: The Division of Vocational Rehabilitation, The Board of Education and Services for the Blind, The Connecticut State Employment Services, school programs for the retarded and brain-injured, parole officers, and private rehabilitation agencies. This total experience has convinced me beyond any doubt that we should not only continue the program of the Division of Vocational Rehabilitation, but that we should greatly increase its scope, since the Division of Vocational Rehabilitation is, in my opinion, the most effective of these agencies.

As of May 14, 1968, the Hartford Element Company had a total of forty-one hourly-rate employees (the number varies from thirty-eight to as high as sixty-five during a year) of whom twenty definitely qualify as handicapped under one or more criteria, as follows:

mental illness: seven (one alcoholic included)

retardates: eight (including brain-damage cases)

physical: six (includes diabetes, deafness, limb and digital loss, vascular and lumbar difficulties, but excludes vision loss or impairment) blind: two (includes one totally and one legally blind)

The total of the above is twenty-three, since some individuals have multiple handicaps.

Of this group, classified as handicapped at the time of employment, thirteen at present indicate that they are rehabilitated and should continue to be self-supporting and tax-paying as indefinitely as any individuals in our present society. Of these thirteen, nine were referred and brought to us directly by the Connecticut Division of Vocational Rehabilitation; of the remaining six, three were referred by the Connecticut State Employment Service; and three were referred by other agencies. The other seven people have either been with us for too short a period for any definitive prognosis, or continue to have difficulties which may or may not be overcome.

A comparison of attendance records between the "handicapped" and other non-handicapped employees is most revealing: the average loss of time per employee in the past year for the handicapped is seven days. Non-handicapped regular employees missed an average of eighteen days each! The competitive earned wage rate for the handicapped shows no variance from that of other employees.

We are usually able to teach the handicapped, except the retarded, every operation in the shop. The retarded show some limitations as operations become more complex or require any high degree of perceptive judgment and skill.

One of the prime factors of our success in employing these handicapped is the assistance received from the Division of Vocational Rehabilitation office. They help solve problems which occur. The Division provides counseling and allowances for training to be given the handicapped at the workshop and in private conferences. The Division also supplies the background information to the employer, which increases understanding and provides the employer with skill to help the employee successfully accomplish the adjustment to the competitive job situation.

On the basis of the minimum wage, $1.60 per hour, for a 40 hour work week (most of our handicapped receive much above the minimum wage,) we have at least thirteen "handicapped" persons, for whom the local, State, and Federal Governments were previously paying entire to partial care - at Mansfield, at Norwich, as welfare cases, -- earning $64.00 per week each or $832.00 per week as a group. They are now tax-paying individuals supporting themselves almost without any assistance and, what is even more important, they have become productive and valuable citizens not only to society but to themselves.

Just how this fact of creating useful and responsible citizens in the place of dependent and ill citizens can be evaluated in the dollar-pattern is difficult to determine. I doubt, personally, that this is a valid method of fixing the value of the Division of Vocational Rehabilitation. However, I'm sure that the long-term effects of the program would definitely be convincing evidence that the monies expended on the program are a wise and exceedingly necessary expenditure for both public and private funds.

With additional funding for more counselors, more workshop facilities, more medical treatments and evaluations, and more psychiatric care, Connecticut can continue to pioneer and excel in rehabilitation of the handicapped from the infant with a birth defect to the geriatric-aged individual for the benefit not only of the coffers of the State, but also for every aspect of our total society. Re-equipping a wife and mother to care for her family and home is of immeasurable value; training a retardate to the limit of his abilities is of immeasurable value; retraining a wage-earner to new skills commensurate with his post-accident or post-illness condition is of immeasurable value.

I earnestly hope Connecticut will ever broaden the scope of this program now, and in the years ahead.

Comment by
Ann Switzer: If I may, I would like to make an observation here, remembering Mr. Davis' testimony, and the stories of difficulties with the "hardcore". Mrs. Irwin, in her report, did mention the need for more workshops. It looks, from her testimony, as though there is an opportunity for a good deal of changing the atmosphere and situation, and using a little flexibility to assist in the "hardcore"; but you recall Mrs. Stabler talking about how failures appearing in her workshop seemed to stop being failures, once they began to attack the problem and work patiently and carefully with it. It is like toilet training. This seems to be a problem at home, but when we get some of these people at a residential camp for the retarded little kids, toilet training doesn't seem to be a problem anymore. If don't know if there is an analogy there or not, but I think it is worth mentioning; and one of the things that I would like to ask of you people who have not yet spoken, or who have spoken, is whether you would like this advisory committee to think in terms of recommending some kind of financial help for the establishment of workshops. I know money is a terrible thing to talk about, State money anyhow, at this point, but I am going to be brave and say that we are going to have to think of money if we are going to expand services the way some people have suggested. Now, the experience of people working with the physically handicapped and mentally retarded indicates, as Beth Stabler has said, that we know the answers to certain questions and we should base our planning on the answers to questions that we know. We know, for instance, that it is expensive to set up a workshop and run it as it should be run, so that it will have the atmosphere in which to do the kinds of things Mr. Davis hoped would be done with the hardcore unemployed. So I am just posing, to all of you and to the members of the commission, whether this isn't a very serious consideration. New York State, at this time, is contemplating this; they have a bill before them for a subsidy for workshops and workshop people. I know that it is a frightening thing to know that we don't have any money now, and that we may not have much more in the future; but if this is a good concept, I think the commission is going to need some very good documentary evidence that it's worth posing to the General Assembly in 1969, and some of us right here in this audience are not afraid to fight for things that cost money.

TESTIMONY OF CARL V. PULEO, EXECUTIVE DIRECTOR, GOODWILL INDUSTRIES OF CENTRAL CONNECTICUT, INC.

As Executive Director of a private sheltered workshop being utilized by the Division of Vocational Rehabilitation and the agency providing services to the blind, I am very much concerned about the effect of the limitation of funds needed by the State agency to provide necessary services to our handicapped citizens.

The present counselor's caseload is expanding, thus limiting the amount of time spent in planning and coordinating rehabilitation plans for individual clients. With a counselor staff freeze but an increase in the backlog of citizens needing case services, the results will be superficial case services at best, creating a frustrating dilemma for the present counseling staff, but worse, denying needed services to handicapped individuals who must have these services if they are to move again into the roles of wage-earners and taxpayers.

If the Division of Vocational Rehabilitation runs short of case service funds because the State does not appropriately match the Federal Government funds allocated to the State, again the counselor staff cannot be as effective as necessary in providing the needed services planned for handicapped clients. When funds are no longer available to follow through these services, the handicapped client suffers.

A. Many times the projected rehabilitation services must be delayed, often creating added hardships on the client.

B. The private agency may be asked to continue clients without renumeration. This often puts undue burden on an agency that may be operating at a slim margin or even a deficit.

The primary goal of the Vocational Rehabilitation Agency and the agency providing Services to the Blind, is to assist handicapped persons back into the mainstream of economic life. This means that the end result of the funds spent on rehabilitation is moving the handicapped person from the status of tax user to that of a wage earner and tax payer. Thus the cost per rehabilitated client is reduced many fold by the person's own contribution to our society over the years.

Spending dollars on rehabilitation is no stop-gap holding measure. Funds spent on rehabilitation as carried out by these excellent agencies are investments which pay dividends to us taxpayers, dividends in the form of more purchasing power and an increase in the number of taxpayers.

It is seriously hoped that, in keeping with the progress already made in the field of rehabilitation here in this State, the economically sound allocation of needed funds and relaxation of staffing restrictions will be made.

TESTIMONY OF JOSEPH BURNS
MUSCULAR DYSTROPHY ASSOCIATION

The Present Status

As defined in the program of the Division of Vocational Rehabilitation, rehabilitation is the program designed to develop and restore the working usefulness of the physically and mentally handicapped civilians to the point where they may become gainfully employed. (State Manual: 1967 edition, p. 219)

Apparently, because of an erroneous interpretation of the medical prognosis of muscular dystrophy, or, because of assumptions based on superficial evidence, public and private agencies committed to programs of rehabilitation have shown a reluctance to admit persons afflicted with muscular dystrophy to their programs. This stance might be attributed to blind adherence to regulations based on unchallenged conclusions; decision makers engaged in such a tortured syllogistic exercise as: dystrophy is a progressively debilitating disease; John Doe is a dystrophic, therefore John Doe fails to meet the standards of acceptance. All this without giving J. Doe the benefit of a test whereby he might prove himself capable of improving his position. But whatever the accurate analysis of the reluctance might be, the reluctance has been all too obvious, as many a disheartened dystrophic is witness.

In recent years we have noted a happy change. By dint of untiring importuning, one or two persons with muscular dystrophy finally convinced rehabilitative agencies of their determination and ability to pursue a course leading to self-betterment and self-support. The agencies--and we commend them highly--gambled, as it were, and the gamble paid off handsomely: the subjects reached their goal, and the agencies had cause to cheer.

At this time there are approximately 150 persons in the State of Connecticut in the age group 8 to 50 who are afflicted with one form or other of muscular dystrophy. Many, if not most, of them are capable of being rehabilitated to a point of partial or total self-support. To our knowledge, by far the greatest number are not engaged in a program of rehabilitation.

It would seem that the key to society's failure has been its obsession with the handicap rather than with the personality of the handicapped. As one dystrophic--himself an escapee from the prison of restriction--put it: I am handicapped only when I admit to being so.

Closing the Gap

Steps toward establishment of an integrated and meaningful program of rehabilitation for all persons disabled by physical or mental disease would include the following:

(1) Motivation of parents: negative attitudes developed within the home become the initial obstacle to the handicapped's escape.

(2) Full implementation of already existing programs designed to aid the handicapped improve their position: this step might call for some amalgamation of public and private agency facilities and staffs.

(3) Accommodation of the handicapped at all grade and high schools, or at a school especially designed for their needs

(4) Planning for transportation: One of the chronic impediments to integrated schooling for the handicapped is inadequate facilities for transporting them to and from school. Vehicles equipped with safety devices such as seat belts and attached lifts should be made available; and sufficient manpower provided to give physical assistance in loading and unloading.

(5) Testing at early level: Aptitude testing should be applied during the junior year in high school to allow for measuring a student's qualifications, either for college entrance or for enrollment in a non-academic setting.

(6) Funding for tuition: The program should enviision the need to underwrite the cost of training either at college or vocational-training school.

Conclusion

Employment of the handicapped is largely a meaningless advertising fillip, as long as society places the stress on the physical or mental restriction. Just as it has been accepted as normal for persons free of obvious impediments to choose life careers calling for mental and artistic creativeness, it must be similarly agreed that persons deprived of a normal function are yet capable of achieving in areas beyond the scope of the handicap to interfere.

It has been demonstrated, dramatically at times, that persons hobbled by some disease have, largely by their own initiative and incredible perseverance, achieved preeminence far beyond the peak envisioned by even their most ardent supporters. Perhaps, if the ways were made smoother and the climate less alien, our so-called handicapped would make the hitherto wondrous seem common-place. Society has, as its least commitment, the pragmatic inducement to make it so.

TESTIMONY OF BEATRICE R. FLEESON, EXECUTIVE DIRECTOR, THE GREATER HARTFORD ASSOCIATION FOR RETARDED CHILDREN, INC.

We believe that there is an urgent need in Hartford, and all of Connecticut, for vocational education and training that is specifically planned for students with varied learning disabilities. This special training should begin near the age of fourteen.

Included in this group are the mentally retarded, culturally deprived, physically handicapped, emotionally maladjusted, neurologically impaired, and socially immature. In cities such as Hartford, fully one half of the students (if the culturally deprived are included) suffers from one or more of these handicaps. Many students are potential school dropouts, while others are bordering on the fringe of delinquency. A large percentage is deriving no benefit from the academic aspects of their school experience.

There is no way of knowing how many young people have already dropped out of school at age sixteen, and are now part of the unemployment and juvenile delinquency statistics.

At the present time there is no existing program to help evaluate and develop these students' vocational skills. Present vocational programs do not have the capacity to accommodate these students who need many diversified special services if they are to become productive citizens of our economy instead of tax burdens of the future.

Many of the physically handicapped and mentally retarded at present do complete the specially prescribed courses of study, but do not, in reality possess the skills necessary to make them independent, or semi-independent.

We urge that an Occupational Training Laboratory be established in all urban communities, as an integral part of the official school system.

An Occupational Training Laboratory would:

1. Provide an initial orientation to a work environment, thereby helping students to learn how to make an adjustment to such an environment
2. Help students to assess their vocational interests and aptitudes and to identify problems which may be deterrents to vocational success
3. Develop increased vocational awareness and sophistication.
4. Provide personal adjustment training related to the following potential areas: personal hygiene, appearance, and demeanor; getting along with others; accepting and benefiting from supervision; and improving work tolerance to the point of being able to spend a full day in sustained job effort
5. Improve work attitudes and work habits, including attendance and punctuality
6. Prepare students for early entrance into industry after school graduation, by offering them a bridge between school and actual work

The Occupational Training Laboratory should be designed, equipped and staffed to provide students with a variety of vocational exploration and skill training.

Question from Dr. Sanborn: Mrs. Fleeson, I believe that you mention age 14 as being approximately the time when a youngster might start vocational rehabilitation. Do you have any suggestion as to what might be done prior to this time so that all of a sudden we don't say, "As of your 14th birthday we start you on rehabilitation."

Answer: Well, ideally, of course, the entire school programs should be expansions of Headstart with the supporting services all along in examination of the curriculum, so that at age 14 there isn't a cut-off between academic and vocational training. That is true. All aspects being worked on all at once would be ideal. It could be.

OUTLINE OF REMARKS - REPRESENTATIVE ARLINE RYAN

GOVERNOR'S COMMITTEE ON REHABILITATION

I Introduction

II Reasons for Concern

A. Step-child of the Education Department

1. Why in Education?

a. Tradition? Small segment of any program

1) Today's recognition and new emphasis on importance of program

2) Quote statutes - To provide guidance, training, medical services and placement for physically and mentally handicapped adults

3) Quote budget document. Page 298 under "fixed charges". "Rehabilitation covers the cost of services to individuals such as:

Examinations
Surgery and Medical
Prosthetic applicances
Hospital and convalescent care
Training and materials
Maintenance and transportation
Tools and equipment purchases"

b. Budget for rehabilitation lost under massive education budget

c. Would be lost under:

1) Welfare (Work retraining - Social Security - Labor)

2) Department of Health (mentally retarded)

3) Department of Correction (special project handled by Division - good job, etc.)

d. Delighted with Division status, but still confined

1) Probably should wait until all rehabilitation can be coordinated

a) duplication in departments although good cooperation

B. Concern over lack of knowledge of services in legislative body

1. accepted as part of Education

2. need of a well-informed lobby to present case

a. lobby in purest form. Do not mean pressure alone.

1) Personal experience

2) Much better than before

b. Use private organizations active in rehabilitation

1) My observations - work well with the Division

2) Division largely responsible for private organizations receiving large sums of Federal money

3. Breakdown of information given to other committees, such as Education, Welfare, and Public Health, and then given to Appropriations Committee

a. Time is short

b. Small segment of budget

C. Study Committees

1. Watch out for matching funds

a. Available in hundreds of programs

1) Appropriations Committee aware of cost to State

a) one reason for tremendous deficit

2. If possible, report before session.

a. Time limited

b. Hundreds of reports never read

3. Contact legislators soon.

D. Rehabilitation gives more for money expended than other programs.

1. Keeps subject off welfare.

2. Keeps subject out of institutions.

3. Keeps subject out of jails.

4. Real investment in human dignity

No one can question the fact that there are similarities between alcoholism and drug dependence. Let us look at some of them:

1. Both alcohol (a drug) and other drugs are chemicals which can give comfort -- if only temporary.
2. Both have legitimate channels where the dangers are small, if they are used correctly and with respect.
3. Both are controlled by laws and legal regulations which are not rigidly enforced, -- and let's be honest -- they probably cannot be rigidly enforced in our present society.
4. Both are human problems which most people do not understand and, therefore, the addict or the alcoholic feels disgraced, guilty, frustrated, resentful, or self-pitying.
5. Both addictions have been considered a sin or the result of weak character, and many of our present laws are aimed at punishing the victims.
6. Both alcoholics and drug addicts have found dangerous solutions to present problems, and need to be rehabilitated to find healthy solutions to their problems.
7. Both have been neglected by the helping professions.
8. The only known cure for both conditions is abstinence.

(If anyone is having a problem with alcohol, drugs, or crisis situations, there is a telephone number at Connecticut Valley Hospital known as "Help-Line-Number 346-8611". It is manned 24 hours a day.)

Busy parents do not always discover the views of other parents or other children, or even the views of their own children.

This brings us to alcohol and drug dependence education. This is a broader field than merely the prevention of alcoholism and drug dependence.

Since the causes of alcoholism and drug dependence are not specifically known, it is difficult to develop a program to this end. In most literature, a multi-faceted approach to prevention is suggested. This includes research, application of mental hygiene principles, and the development of culturally acceptable controls which will lower it in an approach to meeting social and psychological stress and tension. With symptoms already present, the real task is one of re-education. What usually passes for education to prevent alcoholism and drug dependence is actually education about it.

It is aimed at those interested in knowing the causes, progress, treatment, and outcome. What contribution this makes to primary prevention is anyone's guess. Alcoholism and drug dependence are too often the result of poor child-rearing practices. We need to provide adequate character and personality development that will lead to the solution of human problems without the need to resort to chemicals. This is preventive medicine.

The treatment and rehabilitation at Connecticut Valley Hospital is no different from other institutions, which are trying honestly to help the alcoholic or drug dependent patient. It is in a constant state of flux. At present, we are using a combined approach to the problems of alcoholism and drug dependence. Allow me to give you an example:

After about a year's sobriety, I realized that part of my problem was semantics. Recently, I came across some information concerning an investigation conducted by the late Wendell Johnson, Director of the Department of Speech Pathology and Audiology at the University of Iowa. It is called, "Self-Communication Factors in Clinical Counseling". This method is based on the relation of language and behavior. Our thinking is largely what we tell ourselves, and we tend to act as we think.

The problem solving potential is translated into techniques and procedures which, among other things, bring the tape recorder into the counseling process to facilitate the counselee's self-communication. In a crude way, I have already put it to use. It is a fascinating study.

Differences in social structure, personal or cultural attitudes, and the prevalence of dependence on various drugs have to be taken into account. We see a great deal of dependence on alcohol and other drugs. Drugs are often used in combination; for example, barbiturates, together with heroin or alcohol. Many persons dependent on alcohol use sedatives and stimulants at the same time. They will take barbiturates as a sedative and then resort to amphetamines as a stimulant to wake up. This brings us to the multi-disciplinary treatment and rehabilitation needed. Allow me to paraphrase technical report #363 of the World Health Organization:

The professions involved in a treatment program should include: general physicians, psychiatrists, internists (internal medicine), rehabilitation counselors, sociologists, clinical psychologists, social workers, nurses, psychiatric aides, occupational therapists, and members of Alcoholics Anonymous. The practice adopted in some areas, of including in the therapeutic team patients who have recovered from dependence on alcohol and other drugs is to be commended.

The difficulties in coordinating representatives of all of these groups into an effective therapeutic team are well recognized. Special efforts are therefore needed to ensure the creation of an atmosphere of mutual concern for clients, disciplined criticism of techniques, and good clinical demonstration. The requirements include:

(a) A clear understanding on the part of all members of the team, of the contributions made by each discipline to the therapeutic process

(b) A clear delineation of the role of each member of the team in relation to a particular client

(c) A conscious attempt to minimize the barrier of professional jargon

(d) Provision of leadership, without reference to professional discipline, by those with organizational ability, human understanding, and the ability to stimulate initiative.

The various skills represent a great strength in any treatment if they are well co-ordinated to the benefit of the client. If they are not co-ordinated, the client's needs are often not satisfied, despite a flurry of activity. The prevention of dependence on alcohol and other drugs additionally involves the talents and experience of persons as diverse as sociologists, cultural anthropologists, epidemiologists, economists, educators, industrial and other managers, labour leaders, criminologists, attorneys, legislators, jurists, law-enforcement officers, clergymen and historians.

Research involves still further disciplines, such as pharmacology, toxicology, biochemistry and physiology.

The alcoholic or drug addict is a person capable of disrupting the entire social order to gain immediate relief. He is a phony, a con-artist, a liar, and a cheat. If you prefer other terminology, alcoholism or drug dependency is a profound form of emotional illness which is relieved by drugs to the point of loss of control. Alcoholics do not drink, they medicate. This is the only disease named for a medicine which the patient consumes in overdoses.

The real tragedy in alcoholism and drug abuse is the failure to meet the needs of the family, not only from the point of therapy, but in providing support. The family need is AA, Al-Anon, and Alateen, or N.A. We have A.A. and Al-Anon at Connecticut Valley Hospital. In summing up, each case of alcoholism, or drug dependence, is different and each recovery process has its variations, but there are some basic common denominators.

1. It takes two or more persons to produce and sustain alcoholism or drug dependence. Therefore, recovery is a product of two or more persons becoming involved in the process.
2. Waiting for the alcoholic or drug addict to want help can prove to be fatal. In the process, the family can be destroyed emotionally if they do not separate from them or receive competent help.
3. Voluntary programs of recovery are rarely successful. AA started the most successful program in 1935.
4. The earlier treatment is started, the better the chance of recovery.

One of the most gratifying aspects in Vocational Rehabilitation Services has been the interest evidenced by various groups in studying and evaluating new methods and techniques which might prove more effective in the total rehabilitation of the alcoholic or drug dependent client.

As we increase our knowledge we stand better prepared to intercept the insidious growth of this problem, which is a threat to our national economy, security, health, and social stability.

Question from Art DuBrow: Are you on the staff of the hospital?

Answer: I am on the hospital staff, that is correct.

Question from Art DuBrow: Do you bring your conferees to the point of job readiness or is this an ongoing process? What I am interested in, if you have an answer, is are you involved in the placement process and if so, what success have you found?

Answer: I am involved in the job placement in the Middletown area; there are roughly about 18 or 20 companies who will accept the alcoholic. There haven't been too many drug-dependent people who wanted to work in the Middletown area. In New Haven, for example, there are several companies, who are willing to interview, test,and accept the alcoholic or drug-dependent person. In Waterbury, I am getting over there late in one sense. I have been at the hospital two years. You can only get so far...it is a question of time, but in Waterbury the larger companies have been receptive. In fact, as an alcoholic, I was very interested in starting a half-way house in Waterbury and one of the people incorporated one, in fact, on the basis that there was a need for a Half-Way House there. Some of the people on the board of the institution are members of such companies as Scovill, American Brass, American Time, etc.

Question from Arthur DuBrow: I have one last question. Is there any relationship in your work, with the State DVR counselor?

Answer: There have been, up to last week, two DVR counselors at Connecticut Valley. During the last week, one of them was brought up to Hartford, and it is my understanding that someone will take his place. I often will refer people to DVR from our unit. In the two years that I have been with the unit, we have processed over one hundred alcoholics in the DVR. Not all with the success that I would like to be able to stand here and tell you about. I think some of it was trial and error. We are talking about something that takes time. It is an investment in time.

Question from Ann Switzer: After listening to you and Mr. Morrison, I get the feeling that there is a turnover of counselors. They are either transferred or get so good that they are promoted. I have the feeling -- and many of my rehabilitation counselor friends have had the feeling, too -- that as we get into the field of rehabilitation counseling with emotionally-charged patients (if you want to call the group that you work with, and the mentally retarded, mentally ill, by this name), that this is a deft kind of counseling that takes a great deal of time and skill... I think that what I am saying is that the Division, at this point, is being pressured to report successful rehabilitation cases to Washington because it is a Federally-matched program. Do you feel that the qualifications of rehabilitation counselors working in the area of drug-dependency and alcoholism demand a different kind of person and a different kind of training; and, if so, what would you say was the need -- because I think we hope that, out of this study will come, not only more money but more interest on the part of the general public and the legislators. I think those in professional leadership roles within the Division would like to be able to say, "If you want us to do this kind of job, we need this quality of personnel."

Answer: This sort of puts me "over a barrel". I think that in answering your question concerning the type of rehabilitation counselor needed, there are a great many non-alcoholic counselors who are close enough to the problem and have feeling for the client. However, it is very frustrating work -- there are a great many frustrations in working with the alcoholic or drug-dependent person. These frustrations will probably get under the skin. I think there is some way of getting certain arrested alcoholics who are interested in doing this type of work... It's not easy... You have got to have the ability to give what I call "tough love". You've got to be able to comfort the person you are working with, at almost any time. You have got to be able to give almost unlimited time. They are great people to manipulate. It is part of the sickness. I don't think there has been a tremendous turnover. In the two years that I have been at the hospital, there has been a total of three DVR counselors there. At the present time, of these three, one is still there. Another was there about one and one-half years.

> The one who left last week is one who just finished school and started in, and then was moved on, into another area. This work takes a particular type of person. I think this should be stressed. The alcoholic or drug-dependent person can almost defeat other people in trying to keep people away from them.

TESTIMONY BEFORE THE PLANNING COUNCIL FOR VOCATIONAL REHABILITATION SERVICES, MAY 14, 1968
JUDICIARY HEARING ROOM, STATE CAPITOL, HARTFORD, CONNECTICUT

I am Robert E. Bacon, a resident of West Hartford, immediate past president of the CAMH, and a member of the president's committee on the employment of the handicapped. Today I am speaking on behalf of the CAMH for their president, who was called out of town.

I would like to draw the attention of this committee to one area of vocational rehabilitation in which Connecticut is not doing nearly enough. Although Connecticut has an exceptional program for the vocational rehabilitation of the physically handicapped, we are still lagging badly in providing rehabilitation services for the emotionally handicapped, particularly the former mental hospital patient.

Prejudice against the physically handicapped worker has almost disappeared, among employers and co-workers. The days when a blind worker could only weave baskets and make brooms is in the past. Many blind workers are now doing some of the most delicate electrical assembly work and earning as much as their sighted colleagues. We are finding appropriate jobs for the paraplegic and the heart patient. However, prejudice against the former mental patient is almost as strong as it ever was. Although we know that mental illness can be cured, too many people still believe that all former mental patients are always difficult to work with.

At this point, about 30% of all vocational rehabilitation clients need such services primarily because of mental or emotional problems. Most experts in the field feel that even this large percentage of the total caseload, is only scratching the surface, for a vast majority of emotionally disturbed persons who could use the services of vocational rehabilitation agencies are simply are not getting them.

There are a number of reasons for this apparent failure, particularly for the former mental hospital patient. Vocational rehabilitation services in our State mental hospitals are so badly understaffed as to be almost non-existent. For instance, on an average day there are 7,214 patients in residence at our three State hospitals. Yet the total number of rehabilitation counsellors assigned to State hospitals is only six. This means that any one of these counsellors has about 1,300 clients -- an obviously impossible case-load.

Every year our State mental hospitals admit almost 9,000 new patients and discharge approximately 9,400 patients. Unfortunately, many of these people -- 58% -- are caught in a revolving door of admission, discharge and readmission situation. We don't really know all that we should about what makes them relapse. However, we do know that most of the mentally ill lack a feeling of self worth, that many feel unwanted and unneeded, and that this is one of the reasons they withdraw into a world of their own. As all of us here know, there is nothing so important to a person's confidence as a paying job. This is particularly true for the convalescent psychiatric patient. I think that we can safely assume that the patient who has a good job, or who is receiving training, will be less likely to relapse than the patient who has lost all hope that he will ever be a useful member of society. Self confidence is in itself therapeutic. Therefore, providing jobs and hope for former mental patients should be a primary goal for vocational rehabilitation in Connecticut. This means more staff directly attached to the State hospitals and to the community mental health centers which will be opening in Connecticut during the coming decade.

184.

There is a number of programs in mental hospitals in other States which were found to be highly successful. For instance, in Massachusetts and New York, patients receive very specific vocational training while they are still in the hospital. In Connecticut, Norwich Hospital has instituted a secretarial-clerical training course for hospital patients, but the vast majority of activities for patients are still in the occupational therapy category -- i.e. making ash trays, painting pictures, etc. This is not the best preparation for a paying job. Both New York and Massachusetts operate sheltered workshops right in the hospital. In New York State, for instance, Central Islip Hospital has received a number of sub-contracts in electrical assembly, woodworking, and other skills. Patients are paid for their work. In addition they receive invaluable training on how to conduct themselves as employees. We feel that something like this might well be tried in Connecticut State hospitals. Also, in other States patients leave the hospital for trial employment. They work during the day, or for part of the day, and return to the hospital at night. This also is excellent experience, and prepares the patient for a complete return into the community.

Besides needing a job, many former mental patients also need a place to live after they get out of the hospital. Many have no family or have lost touch with family and friends. Others who certainly are well enough to be in the community need the kind of protection and assurance a group living situation gives. In Hartford the Division of Vocational Rehabilitation has cooperated with our Capital Region Chapter in financing the first Half-Way House for former mental patients in our State. The expatient receives training, job counseling, and other help while he is a resident of the group home. Most of these people eventually manage very well on their own. Very few have to return to the hospital. We feel that similar cooperation among the Division of

Vocational Rehabilitation, Mental Health Associations and other mental health agencies in the community might well be the promising course for the future.

Many of our friends and colleagues in Vocational Rehabilitation tell us that the skills needed to work with the mentally ill and emotionally disturbed are somewhat different from the skills needed to work with the physically handicapped and even the mentally retarded. A great many rehabilitation counselors have never had an opportunity to learn about psychiatric disability. Some feel as uncomfortable with the former mental patient, as do a great many potential employers. They don't know what to expect from the former mental patient and sometimes they are even a little afraid of him. This means that this client may actually get less service than the physically handicapped client, although he clearly needs as much.

Our State hospitals and the State welfare department are now providing in-service training and educational leaves with pay for partially trained social workers. They allow time off for these workers to get a graduate degree, and pay necessary tuition costs. A similar program could be developed to provide graduate training for vocational rehabilitation counselors in the area of mental and emotional illness. Such training is now available at the University of Connecticut and at several other colleges and universities throughout the country. Such courses are also available to employees below graduate level. We feel that it would be worthwhile for the Division of Vocational Rehabilitation to investigate the possibility of providing training to vocational rehabilitation counselors interested in working with the former mental patient. This would probably mean asking for some funds from the legislature to provide for necessary education leaves and tuition costs.

One small administrative matter which can be very bothersome to the patient and his family has also come to the attention of several of our fifteen chapters throughout the State. It seems to take a month or more after a client is accepted by the State Vocational Rehabilitation System to receive his first check for maintenance. This leaves many potential clients, particularly the former mental hospital patient, stranded in the community without funds. Several of our Mental Health Association chapters have established emergency loan programs for these patients, but we feel that this is not the best way to handle the situation. Perhaps a way might be found to speed up the processing of applications for Vocational Rehabilitation Maintenance grants.

To sum up, we feel that the field of vocational rehabilitation in Connecticut needs to pay a great deal more attention to the former mental patient and those clients whose primary employment problem is an emotional one. Although 30% of the vocational rehabilitation caseload now consists of people with severe emotional problems, we feel that the vast majority of emotionally impaired persons is not receiving any kind of service. We would suggest that the number of vocational rehabilitation counselors attached to State hospitals be increased sufficiently to allow all patients who need and want a job, after release, an opportunity to work through their employment problem with a counselor. We also feel that plans should be made to attach vocational rehabilitation counselors to all community mental health centers as these centers are opened throughout Connecticut, and that Vocational Rehabilitation agencies should cooperate with Mental Health Associations or other mental health agencies in the community to plan for intermediate living arrangements for former mental hospital patients. In addition we feel that some of the successful in-hospital vocational programs, that have proved successful in other States should be established in Connecticut.

The Connecticut Association for Mental Health also suggests that, since special skills are needed to work with the emotionally disturbed, special training be provided. We feel that a small sum invested in educational leaves for promising counselors, and tuition grants for training to be taken on the job or during an educational leave, would pay vast dividends in terms of vocational rehabilitation service to the former mental patient.

TESTIMONY OF ARTHUR ARSENAULT, VICE PRESIDENT, UNIFORM SERVICES, WATERBURY, CONNECTICUT

We entered into a contract with the International Institute of Laundries' Project Manpower program for hiring the mentally handicapped, January 1, 1966. We received our first applicant from the local Vocational Rehabilitation Center, in September 1966.

As with any new project, we had our reservations with regard to the outcome. After having approximately two years of experience, we feel that it has been a tremendous success, and one which is rewarding to both community and industry. As you know, by placing these individuals in industry, we are making them taxpayers rather than tax users.

We feel that there are needs, at present, for all types of handicapped personnel in our industry, and also in other industries, to fill jobs which are rewarding to them and a benefit to industry.

With reference to our own experience, we have started ten mentally handicapped in jobs. Presently, we have six employed; two left us for advancement and better positions in other industries; and two were not trainable. I am sure that if we had not taken time and effort to help the eight presently employed, they would still be unemployed.

I believe we owe the success of our program to the understanding, and proper training procedures, from the first day. We must be willing, as Management, to take the time to train these people and see that they do not fail because of our inability to recognize their potential, or because of our lackadaisical procedures in hiring and training. But before we can be successful in training, we need the applicants, and this is where the vocational rehabilitation centers must provide industry with the people as, on their own, they would never apply.

No matter how well the vocational rehabilitation centers have tried to teach or train these individuals for industry, on-the-job training and dealing with people on-the-job, in industry, are the successes or failures of the program.

The lead man, or supervisor, or whatever you may call the first line management level, controls the most important phase of success in any program dealing with the handicapped. These Management people are very easily discouraged and must be taught that, with the expenditure of time and patience, a successful program will be an asset to them and make their job easier and more rewarding; because it is a proven fact that these handicapped persons are more dependable and just as productive as regular employees. Therefore, extra time spent, from the beginning, will be more than compensated for in the future.

TESTIMONY OF ROBERT T. MORRISON, ACSW, CHIEF, PSYCHIATRIC SOCIAL SERVICE, NORWICH HOSPITAL, NORWICH, CONNECTICUT

As a Social Work Administrator of one of Connecticut's public mental hospitals, I am particularly concerned with the vocational rehabilitation needs of the mentally ill.

With advances in effective treatment of the mentally ill in recent years, and a slowly changing public attitude toward this type of handicap, we are becoming more aware of the rehabilitation potential many of these persons have. As we move away more and more from the old concept of custodial care for the mentally ill, it is even more necessary that these people have access to appropriate vocational rehabilitation services along with other types of programs to help them achieve and maintain a productive role in society. Perhaps because the history of vocational rehabilitation services for the mentally handicapped is of more recent vintage than for the physically handicapped, such services are less adequate, more fragmented, and less well-coordinated.

There is a need for more vocational rehabilitation counselors who can be assigned to work directly with institutions and clinics caring for the mentally ill. As the skill and experience of such personnel in these assignments grow, they can be increasingly effective in providing vital rehabilitative measures which help the mentally ill toward becoming productive useful citizens. However, I believe such personnel must have special knowledge, skill, and sophistication in the field of mental illness. They must know how to work as members of a psychiatric team. It is extremely important that the rehabilitation candidate's background, motivation, and potential be assessed carefully and that his progress, once he is accepted in a program, be reassessed periodically and that he be helped to overcome pitfalls along the way. The selection of a rehabilitation program that is realistically fitted to his qualifications and potentials is, of course, of primary consideration. Continuity of service as the patient leaves the hospital and returns to the community or moves to another community is essential. A high degree of flexibility and coordination must be maintained between the different rehabilitation resources including the regional offices of DVR, the State Employment Service, and private agencies.

Sheltered workshops and rehabilitation centers have until fairly recently been utilized primarily by the physically handicapped. It is still difficult to enroll a person whose primary diagnosis is one of mental illness in such a program, even though the services are often appropriate and geared to his needs. The person who is recovering from a prolonged illness of this kind often needs a protective work setting under competent supervision, to help him build up his work tolerance and his self-confidence to the point where he can successfully take on a job in private industry. For these reasons more such facilities, open to the carefully selected mentally ill person, recovering from his disabilities, need to be established and located at points throughout the State, reasonably accessible to him.

Subsidized work programs have proved successful as another means of furthering the rehabilitation of the mentally ill. Private employers have shown a willingness toparticipate in such programs. Funds for the expansion of such programs would hasten the return of more of the mentally ill to productive employment. Halfway Houses for the mentally ill are often subsidized through vocational rehabilitation agencies. The Niles Home in Hartford is an example. This provides a temporary home for patients who are employable but who have been hospitalized for a relatively long period of time and have no homes of their own to which to return. They need a "Halfway" setting between hospital and full self-dependency in the community to enable them to regain their confidence and to throw off their dependence on the routine of the hospital. Most of them move out on their own after a short period in the Halfway House, a move they would not be able to make without this intermediate step. More of these facilities are needed as one phase of the State's coordinated rehabilitation program.

An adequate rehabilitation program including expanded service for the mentally ill as described above, will be expensive. However, my belief is that this will be a sound investment which will more than pay for itself through a substantial increase in the number of persons with mental handicaps returning to self-dependent status in society.

Question from Ann Switzer: I would like to ask you, do you have the services at Norwich State Hospital of one full-time counselor, or must you have different ones coming in from the district offices?

Answer: We have two counselors now, and we also have, to some extent, the services of counselors in the various offices from different parts of the State. For example, as our patients move out of the hospital, a Hartford resident is picked up by the Hartford office of the Division of Vocational Rehabilitation, and so on.

Question from Ann Switzer: Are these two counselors DVR counselors?

Answer: Yes, they are. They have office space and working facilities in our hospital, but they are responsible to their own DVR people. They have staff meetings, see patients throughout the hospital, right after admission, in most instances. They work very closely with our staff, as I indicated. It is very important for them to keep pace with the patient as he improves.

Question from Ann Switzer: Do you feel that rehabilitation counselors are well accepted by the medical and other professional members, and are considered a vital part of the team within the hospital?

Answer: Yes, I think they are ... of course, so much depends upon the sophistication of the counselor. I will say that the counselor we have now is accepted and we are very happy to have him.

TESTIMONY OF SENATOR CHARLES ALFANO, CONNECTICUT LEGISLATURE

The economic loss, due to disability, in the United States is large. It is estimated that between 3 and 4-1/2 million adults are prevented from doing remunerative work and another 3-1/2 million are limited in the amount or kind of remunerative work they can do. Conservative estimates place the loss of earnings by these individuals at eleven billion annually.

The statistical record of State-Federal Program of Vocational Rehabilitation in the United States is impressive. Since its inception, the program has grown steadily. In 1940, after 20 years of operation, it successfully closed the cases of almost 12,000 handicapped persons. The number of rehabilitation cases has increased annually since then and, in 1962, exceeded 100,000 persons. It is estimated that the number of rehabilitated cases in 1967 is substantially larger.

Data for fiscal years 1961 and 1962 show that about 2/3 of all rehabilitants who had found remunerative employment had an estimated annual earning rate of $2,500.00, or more. More than 1/10 had estimated annual earnings in excess of $4,250.00. Present day data would indicate that these figures have increased considerably.

The economic value of the rehabilitation program in the United States can be obtained by comparing the increase in the estimated annual earnings with the cost of the program. A comparable analysis between these two factors would disclose that the estimated total annual increase in wages of the rehabilitants is very much higher than the cost of the rehabilitation program.

A cost benefit analysis made in 1966 found that, because of vocational rehabilitation services, the clients whose cases were closed during the fiscal year of 1966 will experience an increase of $35.00 in their earnings and value of work activity over their working lives for every dollar expended on them. In the State of Connecticut, the average cost of case service per client is $463,00. Applying the benefit analysis to this cost would indicate that, in Connecticut, the State is receiving substantial gains from its rehabilitation program.

What do all of these economic statistics regarding rehabilitation indicate? We are all aware of the fact that the rehabilitation program benefits the rehabilitant and society in many ways,

(a) Reduces the cost of disability
(b) Returns the disabled to gainful employment
(c) Reduces welfare rolls
(d) Reduces the number of people required to be institutionalized
(e) Makes the rehabilitant a happier and more contented citizen who can make a valuable contribution to our economy

These factors we all accept. Very important, however, is an economic analysis of the rehabilitation program which would prove that it is an excellent investment in people by our Government. Looking at the program as a practical business proposition, we find that it, in effect, reduces the tax liability, due to increase in taxable earnings of the rehabilitant. The rehabilitant, gainfully employed, gives a return in tax dollars to Goverment - many times the cost invested in rehabilitating him. He, as a productive part of society, can now pay municipal, state, and Federal taxes in the form of excise taxes, sales taxes, income taxes, and many others.

Past rehabilitations in the United States have contributed to the amount of national income in this country. It is estimated that this sum is now in excess of one billion dollars. As the rehabilitation program grows in the United States, the contribution to the future national income will rise considerably.

TESTIMONY OF F. THOMAS ULRICH, R. P. T., DIRECTOR
EASTER SEAL CENTER OF SOUTHEASTERN CONNECTIUCT

The need for out-patient rehabilitation services in Eastern Connecticut has been talked about for a good number of years. Since I am most familiar with Southeastern Connecticut, I would like to emphasize that area particularly - realizing that Northeastern Connecticut has probably equal, or even greater needs.

I will also relate my list of needs, mainly to the broad vocational rehabilitation area, but I feel it important to consider vocational rehabilitation as a part of the total rehabilitation program (medical, psycho-social, vocational - educational). I have not attempted to attach priority to this list of needs because many of them are inter-related. In some of these areas, activity is beginning to develop to help meet these needs, i.e., the development in the past seven months, of our facility and its related programs as an outpatient center, and the development of a Hearing & Speech Center in the past year.

Needs in S.E. Connectict - as I see them:

1. The further development of existing programs and the co-ordinated initiation of programs in vocational rehabilitation, pre-vocational evaluation, work adjustment, sheltered workshop. These should be integrated into a comprehensive rehabilitation facility.
2. A means of transportation for the client to get to and from the rehabilitation facility.
3. Better communication between all institutions, agencies, and other organizations involved in the health and rehabilitation field, to provide for more effective referrals and less time lag in getting the client into the program.
4. The further development of outpatient rehabilitation services tied in with vocational services - these services include physical and occupational therapy, speech and hearing therapy, social service, and recreational and social programs for the disabled.
5. The development of an Information Referral and Follow-Up Service to aid in providing a bank of knowledge for those in need and to gather facts.

TESTIMONY OF MR. NICHOLAS J. LAVRINEVICH
HEART ASSOCIATION, NORWICH

For the forty-two towns in the Eastern Chapter area, we can expect that a total of approximately 702 persons will have a cardiovascular accident (stroke) in a given calendar year. (This is the incidence.)

Further, we may expect, that of these 702 cases, approximately 305 will survive their acute episode to require rehabilitation services. These might range from physical and physio-therapy, to extensive rehabilitation services including the former, as well as the services of speech therapists, neurologists, etc.

If we apply the same *formula for our entire state population, we may expect to have 6,153 number of cardiovascular accidents in a given calendar year and approximately 2,461 survivors requiring rehabilitation services:

This gives us only a numerical indication of what we believe we may expect in each twelve month period. What these figures do not reveal are the hundreds, possibly thousands, of cases which currently exist among our citizens who receive little beyond what we call "custodial care".

The physical suffering, the mental anguish of patient and family alike, the loss of productivity in our society, and the loss of dignity to these hundreds of individuals, who, because of the lack of rehabilitation services, are unable to care for their basic needs, is a matter which has long demanded our attention. The President's Commission on Heart Disease, Cancer, and Stroke, which presented its report to the President in December of 1964 says:

Page 13, "Stroke has been for many years a tragically neglected disease. The health professions have shown little interest in it; the public has accepted it with resignation. At the root of this neglect are several misconceptions. The most important of these has been the assumption that stroke is simply a way of dying after the body has survived all the other ravages of time - as inevitable as death itself."

On pg. 14, "Intensive modern rehabilitative care can restore as many as 80% of stroke survivors to relatively active and productive living. A well defined and tested program of medical rehabilitation has been developed which, if started early enough and carried through, can make the difference between total dependency and self-sufficiency."

*As formulated as a result of a research project by the Connecticut State Dept. of Health in Middlesex County under the direction of Henry Eisenberg, M.D. Chief of the Chronic Disease Section.

1. "Cerebrovascular Accidents; Incidence and Survival Rates in a Defined Population, Middlesex County, Connecticut", Henry Eisenberg, M.D., John T. Morrision, M.D., Paul Sullivan, and Franklin M. Foote, M.D., Ph.D., Hartford, Connecticut.
2. "The Use of Epidemiological Data in Community Program Planning for Cerebrovascular Accidents", Henry Eisenberg, M.D., John T. Morrison, M.D., Paul Sullivan, B.A., Franklin M. Foote, M.D., Ph.D.

TESTIMONY BY FRED F. FINN,
SUPERINTENDENT, SEASIDE REGIONAL CENTER

Considerable progress has been made in the last decade toward the goal of developing rehabilitative services that will insure maximum utilization of each handicapped person's potential. Those of us who are concerned for the welfare of the mentally retarded have seen our society move from an institutional-custodial-oriented program to the community-oriented programs which are being developed across the land. The best example of these new programs exists here in the State of Connecticut and is referred to as the Regional Center Program, under the supervision and direction of the Office of Mental Retardation, State Department of Health. There is a great improvement in the quality and quantity of services that are provided to mentally retarded persons as compared to ten or fifteen years ago. The vocational rehabilitation services, as they affect the mentally retarded have also made considerable progress. We are very appreciative of the interest, support, and efforts that have been shown by those in vocational rehabilitation as they work with us in developing the comprehenisve service program that we all deem so advisable.

We have made this progress in vocational rehabilitation services and in the other service areas because people have been willing to become involved and, as they become involved, are willing to change existing patterns so as to meet, more appropriately, the needs of the retarded who are referred.

We recognize the advance that has been made and, because of the efforts of all concerned, we are now able to provide alternatives to residential care in an institution or center. We also have greater resources available to effect the return to community living for many of those who have already been placed in an institution or center. We now have the resources, and are continuing to develop these resources, so that mentally retarded persons can live as members of a family unit, can be engaged in worthwile productive activities, can be furnished those essentials needed to develop their abilities - all without placing unreasonable demands on the other members of the family unit. We have come a long way from the day when the first Vocational Rehabilitation Counselor was placed at Southbury Training School as part of a pilot demonstration program. Even though we are willing to recognize the advances,so, too, we must recognize that we have only "scratched the surface" and that much remains to be done in the field of vocational rehabilitation for the mentally retarded if we are to provide for optimum development of each retarded person's potential.

Our efforts must be planned, directed, and implemented on a cooperative basis between the Division of Vocational Rehabilitation and those agencies which serve the mentally retarded. There must be considerably more interaction between these agencies, at all levels of program planning and service implementation.

My comments should not be interpreted as an attempt to detract in any way from the achievements of the past; rather, we are concerned with the future and what lies ahead. I feel that it is incumbent on all who are concerned with the welfare of their fellow man to speak out and delineate areas of need. There can, and should be, improvement; and to this end, I present the following for your consideration:

1. There should be an increase in the amount and kinds of vocational rehabilitative services that are provided by the Division of Vocational Rehabilitation to the agencies serving the mentally retarded. The present counselor staff is inadequate to meet the needs of the large number of mentally retarded persons who could be included in rehabilitative programs if such counselors were available.

2. Research, pilot, and demonstration programs should be initiated to develop more effective evaluation and testing devices for determining the mentally retarded person's potential.

    a. At present, the instruments are woefully inadequate, particularly as they pertain to the mentally retarded, and our techniques at this stage are, by and large, limited to the trial and error method.

    b. Pilot programs should be developed to explore a wider range of job opportunities for mentally retarded persons.

Much more could be done to match job demands to the skills that can be successfully developed by retarded persons. The tendency has been to down-grade the retarded so that they are most often assigned to the menial and subservient job areas. And this is caused by preconceived ideas of what they can or cannot do.

3. Vocational Rehabilitation counselors should be required to participate in on-going in-service training programs that will more adequately prepare them for service to the retarded. It is essential that this training provide opportunities for the counselors to acquire knowledge relative to the mentally retarded person's potential and the techniques that can be employed to achieve this potential.

This in-service program should include opportunities for the counselor to learn up-to-date information on appropriate new vocational placements that are developing as a result of the tremendous changes that are being made in industry. It is our impression that we have not kept pace with the changing world of work. Requirements necessary to succeed on a job five or ten years ago may, or may not, be valid today.

We also think that each counselor should have the most up-to-date information in regard to new legislation, policies, and programs that are being developed at the national and state level, and the status of the implementation of the new program that his legislation makes possible.

4. There should be a study of the differences between the service programs as they exist at the local level, and the philosophies and program design for rehabilitative services as are stated at the national and State level. There seems to be some inconsistency in what we say and what we are able to do.

5. The operational procedures at local and State levels should be amended so as to provide for full realization of the philosophy of the Division of Vocational Rehabilitation. Most simply stated, the bureaucratic procedures, red tape, and "numbers game" that seem to permeate local service programs, and

which constrict local counselors, should be eliminated.

6. The Vocational Rehabilitation program must be adjusted so that service can be provided at all levels according to the needs of the individual being served, and arbitrary limits as to age, degree of handicap, and extent of involvement by the counselor, must be eliminated. We find these limits being imposed because of budgetary factors, interest of counselors or supervisors, case loads, and other such factors which have little relationship to the needs of the person referred for service.

7. The Division must provide opportunities for counselors to become involved in the total life of the client and their activities should not be restricted to the "work day". Living arrangements, use of leisure time, ability to manage money and to meet the demands made of the individual in our complex society - all are important factors in determining whether or not the client is, or is not, successful; and certainly these should be of paramount concern to the counselor. So, too, the counselor should be concerned with programs that prepare the individual for the world of work.

Rehabilitation services should interact with the public schools so as to enhance the development of work attitudes and habits during the developmental years and, to this end, they should and could develop appropriate programs as part of the school curriculum. The rehabilitation specialist could be an important resource in this area.

There is much more that could be and should be said. The foregoing comments are intended only as an indication of some of the problem areas that cause us concern. We are grateful for the progress that the Division of Vocational Rehabilitation has made in the past ten years in providing important services for the mentally retarded, and we look forward to even greater advances in the future.

TESTIMONY OF THE LATE THOMAS B. RITCHIE
FORMERLY CAPITOL REGION MENTAL HEALTH PLANNER

Cooperation, communication, and coordination have long been the goals of interagency relationships, but the quest to achieve them has not always been successful. The attempts, however, have resulted in a better understanding of the elements that effect the Three C's. This report will attempt to pinpoint them, determine their effect, and offer some suggestions.

If we take the client as our point of reference, and follow him from the time that a service is perceived as needed until rehabilitation is completed, it might help to highlight the situation.

1. Awareness that a service is needed.

   This may occur in many ways. An individual may realize it himself, or a member of the family, a professional (such as a physician or minister), or a staff member of an agency involved. The environmental climate of awareness may very well determine the attitudes that people have toward their problems. If the agencies have worked together and developed an environment in which people feel confortable about having problems and seeking help, this may very well increase a person's willingness to recognize early symptoms and seek assistance. On the other hand, if a climate of bickering, long waiting lists, and jealousy exists, a barrier might be present between the public and the agencies offering services.

   This involves individual and joint public relations programs. Agencies need to inform the public of their policies and programs, in general, and create an atmosphere of openness and willingness to serve. Individually, each agency could foster this awareness by having lay people on their policy-making bodies, develop opportunities for volunteer service, and publicize their activities. Jointly, agencies could sponsor public meetings, open houses, and other joint activities which promote communications. Thus, an atmosphere may be developed in the community which fosters the awareness that help is available when it is needed.

2. Motivating person to seek help.

An awareness is not sufficient. The person must reach out to somebody or be reached out to. This involves the variety of services available in a community, their location, and the channels of communication which may be in existence. If the person is self-motivated, he will most likely approach a source with which he has had previous contact and feels comfortable. If not motivated, the person aware may have to provide stimulation, and may involve a network of agencies working together. Services that are neighborhood-based and in close proximity to other services perhaps provide the best motivation. In planning services, agencies may very well involve the consumers and other agencies, so that this proximity may be achieved. It may also be helpful to have neighborhood workers on staffs for contact and reaching out.

3. Determination of needed service.

This is a key factor in the whole process. The awareness that a service is needed may take the person to any one of a number of contacts. From there to the agency, or agencies, that can provide the best service, may be a long and difficult process. Previous agency contacts, background information from family, testing, case conferences, can all be helpful in determining the problem and the service needed. This involves the whole gamut of inter-agency cooperation from exchanging information to having a thorough understanding of roles, responsibilities, procedures, staff, etc.

Close working together is needed for this. Joint staff training, conferences, workshops, institutes, all are perhaps needed to develop the kind of professional trust that is necessary.

4. Providing needed service.

After evaluation, who does it? This may be one, or a number of agencies cooperating. Reports have to be maintained, which could be standardized as much as possible, information exchanged, confidentiality respected, and other referrals possibly made.

5. Evaluation of services.

Each agency should have some method of evaluating services offered. Satisfactory procedures for accomplishing this are still being sought. Subjective types of evaluation are the most common, as objective measures are not too productive. Good evaluation assists agencies in improving services, and forms the base for cooperation with other agencies in planning, developing, and providing services without duplication or overlapping.

6. Dissemination of knowledge.

Many research and demonstration projects are in operation today. The knowledge gained from these, however, is not disseminated in an orderly fashion. It is left to chance and the initiative of individuals, in large measure. More formal channels might be developed for an awareness of ongoing research and demonstration and inter-agency communication developed for closer contacts between researcher and practitioner.

These, then, are the elements of continuity of care, and inter-agency cooperation, coordination, and communication. Attempts to achieve this can be on formal and informal bases, with the goal in mind of providing a service from the time awareness develops until functioning is restored.

TESTIMONY OF ROBERT W. BUTLER, M.D.
MEDICAL DIRECTOR OF SCOVILL MANUFACTURING COMANY
AND PRESIDENT OF THE COMMUNITY WORKSHOP, INC.

When I was asked to come here, I was told it was because, in the field of vocational rehabilitation, I am "knowledgeable". If this refers to many years of experience in the employment of the handicapped and on-the-job rehabilitation, I perhaps qualify; but if, on the other hand, it implies that I have pat answers to all the problems of rehabilitation, knowledgeable I am not!

There is obviously no need here to define rehabilitation, but I would stress the importance of mental and emotional rehabilitation which accrues to the unemployable individual who becomes employable and self-sustaining; or to the helpless person who becomes able to care for himself. In brief, this is restoration of his heritage of human dignity -- one of man's most precious assets. (This term has been tossed about to the point of becoming threadbare, but I have found no adequate substitute.)

My personal experience has been limited to working with the handicapped employed at the Scovill Manufacturing Comany (we now have approximately 593 of these); and to the presently unemployable but potentially employable handicapped individual. In the latter domain, I would commend to your attention the experience of the Community Workshop for the Handicapped in Waterbury -- an organization with which I have been associated in a non-medical capacity since its inception 14 years ago, and an excellent example of what can be accomplished in one sector of the total rehabilitation effort.

The Community Workshop which was and is unique in the rehabilitation field, was started in 1954 by a group of business and professional men and top eschelon industrialists. Unlike most so-called "rehabilitation centers"' it would accept only those unemployable handicapped for whom there was some possibility of future full-time employment in competitive business or industry. It is a non-profit organization which was originally financed by a single solicitation of funds from local industries and a few individuals. It has been self-supporting ever since.

Employment has been provided for every type of handicapped person, except those afflicted with quadriplegia or total blindness, with every possible effort directed toward their capitalizing on abilities, rather than over-concerning themselves with their disabilities. They are referred by physicians, various agencies directly or indirectly interested in rehabilitation, by families of the disabled, and, on occasion, by Workshop employees. A preemployment requisite is a physical examination by the family physician who completes a medical referral form for the guidance of the Managing Director.

All employees -- whether they work full or part-time -- earn while they learn, according to a quasi-incentive schedule. Starting with a minimum wage (which many are unable to earn during the first several months), as skills are developed, they are paid on a piece-work basis; and in due time, most receive remuneration equal to that for similar jobs in the community. At this point, they are ready to "graduate" as soon as outside employment is found for them.

To recapitulate:

The Community Workshop, in 1954, was quartered in an old garage of about 1,000 sq. ft., with 4 employees and an annual payroll of $5,000.

In 1956, a larger building (7,500 sq. ft.) was purchased. Employees numbered 10, and the payroll was $18,044.

In 1966, a 4,400 sq. ft. addition was constructed. There were 100 employees with a payroll of $256,000. A scholarship fund in the amount of $50,000 was established for the handicapped and children of handicapped persons.

Between 1955 and 1966, 171 employees have graduated to private industry and are doing well.

The Workshop story has been told to you because, in my opinion, the unemployable but potentially employable individual has been and is the forgotten man in the total rehabilitation effort.

TESTIMONY OF LILLIAN R. FRANKL, CHAIRMAN OF SPEAKERS' COMMITTEE, BOARD OF DIRECTORS OF THE REHABILITATION CENTER OF SOUTHERN FAIRFIELD COUNTY

As graduates of the Rehabilitation Center of Southern Fairfield County, (Stamford), I, and many of my friends, have been only too aware of the problems created by architectural barriers. We have to live with these problems day by day as best we can; even so, at times, it is difficult and most discouraging. We have learned to make the best of difficult situations; and to get into places that were not easily accessible, I have ridden many a laundry-chute, garbage elevator, and once even the hand-operated elevator of a mortuary, where customers usually don't complain anymore about how scary and rickety it is.

Many of us have learned to live with our handicaps and, in spite of them, lead productive and fairly normal lives. We hold full time jobs and, instead of being a liability to our family or public welfare, we try to be contributing members of the community, taxpayers and producing citizens.

But every so often, we come up against it. It may be any public building, a house of worship, the townhall, the postoffice, where insurmountable Architectural Barriers make it impossible for us to enter and to pursue our business. There might just as well be a sign there saying "No trespassing - This means you!" -- And suddenly a painful doubt creeps into our feeling of independence and equality of citizenship.

It may be a very little, insignificant thing that makes it impossible for us to accept the job we are trained for: a couple of steps we are unable to navigate, or a restroom door too narrow for a wheelchair to pass through.

I, myself, not too long ago had an experience which well illustrates my point. I was looking for an apartment, and found one which would have been the perfect answer to my need in a fairly new apartment house. However, there was one little difficulty, one step up to enter the building. Walking with the help of crutches and long legbraces, I could have managed that with the help of a small handrail to steady myself, and I offered to have one installed at my expense. I was denied permission to do so and, therefore, could not take the apartment. It was such a little thing, - and yet presented such a decisive problem to me, - one that need not have been.

The evergrowing interest in, and understanding of, our problems, - and dialogues like this one today, - give us new hope that some day soon these man-made barriers will be no more, - that we will be free to pursue our business, accept the jobs we are able to fill, that maybe we won't have to ask anyone to pick up some stamps for us, or to ask the minister to our house, because we are unable to visit the house of God.

Only when these barriers -- these "No Trespassing" signs are done away with, shall we truly know that we have overcome; that we can live in dignity, as equals of our fellow citizens, with self respect and the independence we have worked so hard to achieve.

TESTIMONY OF FRANCIS E. MINER, ASSISTANT COMMANDANT, VETERANS' HOME AND HOSPITAL

Let me state, at this first Public Hearing of the Planning Council for Vocational Rehabilitation Services, that the idea and its implementation are commendable, to say the least.

While I may possess some knowledge of veterans' affairs, it seems to me that " rehabilitation" is to "restore:. Therefore, vocational rehabilitation should be for all those who may require it. An occupied mind is the first step on the road to rehabilitation. However, the most basic fundamental requirement must be the person (teacher or psychologist, member of an agency, or just some dedicated person), who, first of all, believes in giving help to someone less fortunate than himself, and is persistent enough to seek out and obtain the proper means of restoring the individual to society, to assume his former position or to obtain the training to pursue a new life.

My allotted time is far too limited for detailed explanation, so I shall offer but a few ideas at this time.

Vocational rehabilitation, as applicable to veterans' needs is designed to help the veteran select, train for, and secure work which is in line with his personal goals, interests, and abilities. In other words:

IF - you are not qualified for a skilled position or a profession requiring extensive training, OR - if the kind of work for which you are qualified is not suitable in terms of your interests and abilities,

AND - your service-connected disability places certain limitations on the type of work you can do,

THEN - you are probably eligible for training.

If you are entitled to VA disability compensation (service-connected disease or injury), you will also want to ask about vocational rehabilitation. You will want to remember, too, that this benefit, like disability compensation, can be looked into at any time in the future if a service-connected illness or injury disables you.

There are many facets to vocational rehabilitation. I would like, at this time, to offer one suggestion: that future consideration be given to the "Community or Health Centers" concept. In this way, the availability of services offered by the Division of Vocational Rehabilitation would be brought to the individual for initial determination.

Extensive facilities in approximately 25 to 30 communities might be utilized by securing space in contemplated growth plans or enlarging present facilities. I cite examples:

Veterans in this area might be accommodated at Rocky Hill on an out-patient basis or by utilizing part of the facility as a determination area.

We should not lose sight of the fact that we are all stockholders in the distribution of Federal Assistance.

Thank you for the opportunity offered me to appear here at this time.

TESTIMONY OF MRS. KAREN KAGEY, EXECUTIVE DIRECTOR, SOCIETY TO ADVANCE THE RETARDED

The rehabilitated retarded man or woman who is a taxpayer rather than a tax-burden is no longer news. The retarded in the community, however, comprise others as well. They are the growing core for whom rehabilitation services must be much more effectively planned.

Among them are those with more marked limitations than now make the rehabilitations grade. Most are multiple-handicapped. Some by obviously impairing conditions such as epilepsy, CP, major sensory defects, etc. Others by more subtly handicapping conditions, among them mental disorders. The field suffers desperately from fragmentation. Having "rehabilitated" the client for one aspect of his condition, or perhaps having reached the no-further-prospect stage, he is either turned loose as "improved" or referred to another center on the basis of some other disability. Retardation, mild or moderate, native, or an operational by-product, becomes in the end another, and this time, the final "primary disability". The field suffers, also, from conceptions of success that demand fast client turn-over, from over-narrow ideas of what is vocationally valuable, and from resistance on the part of too many of the professional establishment to finding new ways of dealing with the problems of the multiply-handicapped persons when devices that work with others fail. The resources for such clients offering more than passing-the-time activities are few and far between for constructive gains are won very, very slowly and then only with a concerted program. The fact that medical advances, which increasingly raise the life-expectancy of the multiply-handicapped-retarded, outstrip preventative gains, foreshadows a growing number for whom new, whole-cloth plans must be laid.

And now to a still more rapidly increasing group - the aging. Already we have a goodly number who for historical reasons never entered the job market, yet yearned to be like others, a breadwinner, a somebody who earned his way.

Take Mr. J. for example, born in 1907, a cretin reported many years ago to be of borderline intelligence, but now among the mildly retarded. Picture a huge round head above a short, squat body, uncertainly supported by matchstick legs. He moves with a labored, lumbering gait. Considered by family and community too crippled, dull, and old-looking to be worth schooling and job training, he managed to while away time, but unhappily. Some fifteen years ago, Mr. J. heard of a rehabilitation center not far away and wangled his way there, hopeful that, at last, he could become a "working man". His stay was short. Stubby fingers and slow tempo soon disbarred him from a vocational program geared to the more able handicapped, and to a timetable turnover to competitive industry. A few years later, Mr. J. found his way to an agency for the retarded which, at the time, could offer only recreational and craft activities. They helped his crying social need and gave him some time-filling hours. When the agency opened a Vocational Workshop, Mr. J., now fifty-seven, was waiting at the door. At long last he would be a man at a man's work. Mr. J. proved a slow but steady, reliable worker capable of doing a variety of simple industrial jobs. Poor health ruled out competitive employment, but not his drive. Since he began four years ago, a coronary laid him low for a while and other ills have made for some attendance gaps. However, unless bedridden, Mr. J. is on deck, or if merely indisposed, sends urgent phone message asking that work be brought him to do at home.

Add to Mr. J. and his generation, those born ten, twenty, thirty years later. All came to adulthood without school and the job training opportunities now available to a younger generation of retardates. Over and beyond these numbers is still another roster of adults for whom new rehabilitation doors must be opened. These are men and women now employed but facing an uncertain vocational future, as the years catch up with them.

2

Time forbids spelling out all the factors that return the once-productive retardate to the ranks of the unemployed, years before those in highly skilled, managerial and professional occupations felt the pinch of time. More vulnerable to economic ups and downs of industry, and with fewer monetary and vocational assets, the retarded adult past his prime finds himself edged out by younger, physically stronger and more agile counterparts. New doors must also open to those with declining abilities, whether due just to age or to other disabling conditions that impair a once "normal" intelligence. If these men and women are to survive with reasonable independence and a sense of self-worth, new prospects are needed. Few want to give up in a change for a subsistence Welfare or Social Security existence which too often grows into a desperately lonely and alienated one as well.

How many of the multiply-handicapped, and those caught in the trap of time, can be readied for competitive industry, remains to be seen. But even under sheltered conditions, the President's Panel reports, they "could strengthen the economy by helping resolve the problems of unemployment, by reducing welfare cost ... and by producing goods and services through expedient use of manpower resources now wasted."

TESTIMONY OF RICHARD K. CONANT, JR.
HEALTH EDUCATION PROJECT
GRIFFIN HOSPITAL
DERBY, CONNECTICUT

In the Lower Naugatuck Valley there are relatively few rehabilitation services that are locally available to citizens. There are many more rehabilitation services available on a regional basis which require traveling outside the area to reach them. However, like every community, the Valley has expressed the need for additional services. It becomes important, then, that a coordinated effort be made to develop the existing few services, create new ones, and tie into regional services. Rehabilitation, as financed through DVR, pays a large share of these services and can be counted on to continue to pay. DVR should participate in the planning of the services it purchases, especially with regard to quality and the possibility of avoiding duplication.

On the basis of what our Health Education Project has observed, DVR can be kept extremely busy in the Valley, working on a variety of individual cases needing rehabilitation services. So much so, in fact, that a full time rehabilitation counselor should be assigned to the Valley area. Better case planning, as more communication with client and referring source is developed, will eliminate an existing gap. This gap has been noticed in Griffin Hospital's Department of Physical Medicine. The Physical Medicine Department is expanding and now offers extensive out-patient treatment services. It needs to have, and would welcome, closer contact with a rehabilitation counselor.

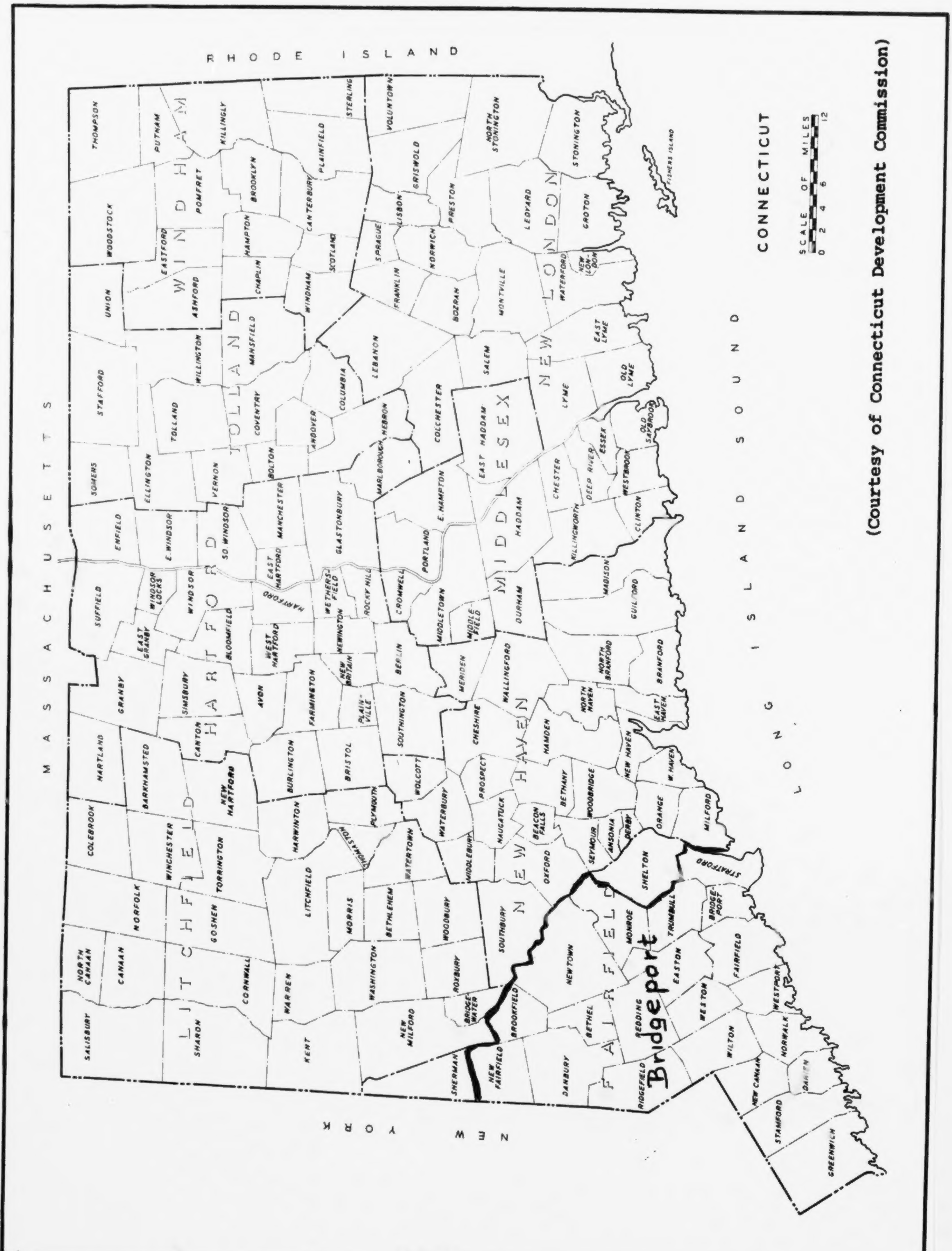
One recurring difficulty is the lack of funds for new cases during the last quarter of the fiscal year. Since this happens with some regularity, DVR has some responsibility to assist agencies in planning for it (since rehabilitation cases continue the year round), and interpreting to the public just what is happening. Is the demand for service so inexhaustible that money always runs out first? The effect of this lack of funds is to create confusion and a tendency to discourage referrals or case finding since, foremost in everyone's mind is the fact that, even if eligible, a long delay may be expected.

Finally, DVR should participate in, or even initiate, planning with communities like the Valley, to use the emerging services, such as Regional Educational efforts, and to encourage enterprises like V.A.R.C.A. (a rehabilitation workshop for the retarded), in order to offer as broad a rehabilitation service as is practical, tying together the services already available regionally.

PROFILES OF DVR REGIONS

AND

REPORTS OF REGIONAL COMMITTEES


RHODE ISLAND
MASSACHUSETTS
NEW YORK
LONG ISLAND SOUND
CONNECTICUT
SCALE OF MILES
0 2 4 6 12
FISHERS ISLAND
WINDHAM
TOLLAND
HARTFORD
LITCHFIELD
NEW LONDON
MIDDLESEX
NEW HAVEN
FAIRFIELD
Bridgeport
THOMPSON
PUTNAM
KILLINGLY
STERLING
VOLUNTOWN
NORTH STONINGTON
STONINGTON
WOODSTOCK
POMFRET
BROOKLYN
PLAINFIELD
GRISWOLD
PRESTON
LEDYARD
GROTON
EASTFORD
HAMPTON
CANTERBURY
LISBON
SPRAGUE
NORWICH
NEW LONDON
UNION
ASHFORD
CHAPLIN
SCOTLAND
WINDHAM
FRANKLIN
BOZRAH
MONTVILLE
WATERFORD
MANSFIELD
WILLINGTON
STAFFORD
LEBANON
SALEM
EAST LYME
COLUMBIA
COVENTRY
TOLLAND
COLCHESTER
LYME
OLD LYME
ANDOVER
HEBRON
EAST HADDAM
ESSEX
OLD SAYBROOK
SOMERS
ELLINGTON
VERNON
BOLTON
MARLBOROUGH
CHESTER
DEEP RIVER
WESTBROOK
ENFIELD
E. WINDSOR
SO. WINDSOR
MANCHESTER
GLASTONBURY
E. HAMPTON
HADDAM
KILLINGWORTH
CLINTON
SUFFIELD
WINDSOR LOCKS
WINDSOR
EAST HARTFORD
HARTFORD
WETHERSFIELD
ROCKY HILL
CROMWELL
PORTLAND
MIDDLETOWN
MIDDLEFIELD
DURHAM
MADISON
GUILFORD
EAST GRANBY
BLOOMFIELD
WEST HARTFORD
NEWINGTON
NEW BRITAIN
BERLIN
MERIDEN
WALLINGFORD
NORTH BRANFORD
BRANFORD
GRANBY
SIMSBURY
AVON
FARMINGTON
PLAINVILLE
SOUTHINGTON
CHESHIRE
NORTH HAVEN
EAST HAVEN
HARTLAND
BARKHAMSTED
CANTON
BURLINGTON
BRISTOL
WOLCOTT
PROSPECT
HAMDEN
NEW HAVEN
NEW HARTFORD
HARWINTON
PLYMOUTH
WATERBURY
NAUGATUCK
BETHANY
WOODBRIDGE
W. HAVEN
ORANGE
MILFORD
COLEBROOK
WINCHESTER
TORRINGTON
THOMASTON
WATERTOWN
MIDDLEBURY
BEACON FALLS
SEYMOUR
ANSONIA
DERBY
NORFOLK
GOSHEN
LITCHFIELD
OXFORD
SHELTON
STRATFORD
NORTH CANAAN
CANAAN
CORNWALL
MORRIS
BETHLEHEM
WOODBURY
SOUTHBURY
MONROE
TRUMBULL
BRIDGEPORT
SALISBURY
SHARON
WARREN
WASHINGTON
ROXBURY
NEWTOWN
EASTON
FAIRFIELD
KENT
NEW MILFORD
BRIDGEWATER
BROOKFIELD
BETHEL
REDDING
WESTON
WESTPORT
SHERMAN
NEW FAIRFIELD
DANBURY
RIDGEFIELD
WILTON
NORWALK
NEW CANAAN
DARIEN
STAMFORD
GREENWICH

(Courtesy of Connecticut Development Commission)

[1] Map of Bridgeport Region

PROFILE OF BRIDGEPORT REGION

I. Rationale for Districting

A. The State Division of Vocational Rehabilitation set up five administrative districts for the provision and administration of rehabilitation services for the residents of towns of the State.

B. The area of each is topographically homogeneous and approximately economically homogeneous. Most of the residents of each area work within the district. For example, of the small percentage who do not work in the Bridgeport District, most of them, or roughly 10% of the Bridgeport District work force commute to New York State. Approximately another 2% of the work force commute to the New Haven District for work.[2]

C. Sub-divisions of each district are frequently taken together as intra-state regions for other planning purposes.

II. Transportation Patterns

Traffic in the Bridgeport District travels mostly east-west as is reflected by the location of the two major expressways along the coastline of the district, U.S. 1 and Interstate 95. East-west traffic on I-84 in Danbury is also heavy. Major north-south traffic is carried by U.S. 7 and Connecticut 25. The locations of these two highways are expected to be the locations of proposed expressways.[3]

All but six towns in the district, Easton, Monroe, Ridgefield, Trumbull, Newtown, and New Fairfield, have passenger railroad service. All but three towns, Easton, Redding, and Weston, are linked by intrastate or inter-state bus service.[4] However, these less heavily populated towns which are not served by public transportation are likely to experience the heaviest population expansion due to the relative density in population of the cities of the district. Complaints have also been voiced that the bus schedule in Norwalk is not adhered to regularly.

A large majority of residents in the Bridgeport District use automobiles as a means to get to work. Additionally, about the same number of people (around 8%) take the bus as walk to work, and only a small percentage less take the railroad.[5] The number of work trips by bus in Stamford, Norwalk, Fairfield, Bridgeport, Trumbull, and Stratford are expected to increase significantly within the next few years.[6]

---

[2] Connecticut Labor Department, Employment Security Division, Commuting Patterns in Connecticut, June, 1966, pp. 9-12, 17-20, 51-54, and 59-62.

[3] State of Connecticut, Connecticut Interregional Planning Program, Transportation, "Connecticut: Choices for Action"; 1966, pp. 18, 35, and 44.

[4] Hartford National Bank and Trust Company, Economic Profiles, Hartford: 1966.

[5] State of Connecticut, Connecticut Interregional Planning Program, Connecticut Development Commission, Connecticut Takes Stock for Action, June, 1964, pp. 99, 107, and 121.

[6] Connecticut, Transportation, p. 49.

III. Topography

The Bridgeport District lies within the grographical regions known as the Coastal Plain and the Western Uplands, although the portion of the Western Uplands in this district is relatively flat in contrast to the more rugged portion in the Waterbury District. Bridgeport's section of the Coastal Plain, bordering on the Long Island Sound, has been well known for water-based recreational activities, but the sharp increase in water pollution is threatening the area's beaches and wildlife.

The larger cities of the district -- Bridgeport, Norwalk, and Stamfor lie on the coast. The relatively flat land of the Bridgeport District, its location bordering on the Sound, and its proximity to New York City have all contributed to the urban development of most of the district.[7]

IV. Economic Data[8]

Just over half of the Bridgeport District's non-agricultural labor force works in non-manufacturing occupations. The only substantial unemployment in the Bridgeport District is in Bridgeport. This problem is aggravated by the out-migration of the white middle and lower classes and the in-migration of Negroes from the deep South, Spanish-speaking people from Puerto Rico, Jamacians, and Portuguese. Many of the migrants coming into the area are characterized by lack of education, lack of marketable skills, lack of long-range career goals, and an unawareness of the community resources for self-help. The remainder of the Bridgeport District is quite economically stable and has low unemployment. The manpower problem in the entire area is a shortage of available applicants who are qualified for available positions. There is a healthy growth of jobs in the district.

Manpower needs forecast are mainly technical (especially electrical and electronic) and professional (with emphasis on the scientific). Some increased need is also forecast for machine trades, skilled office people, and sales and service personnel. The demand for unskilled labor will continue to decrease.

Norwalk has an acute diversity in family income. Family income level for about 23% of the population is under $5,000 while around 34% of the population has a family income in excess of $10,000.[9]

---

[7] Connecticut, Connecticut Takes Stock for Action, pp. 45-47

[8] Connecticut State Employment Service, Bureau of Labor Statistics; Also: Connecticut Labor Department, Cooperative Area Manpower Planning System Report

[9] Connecticut, Manpower Planning, p. 246.

LABOR MARKET INFORMATION*

Area		Non-agricultural Employment		
	Mfg.	Non-mfg.	Gov't	Total
Bridgeport District Totals	128030	129940	27770	285740
		Unemployment		
	Men	Women	Total	Ratio
	7670	6420	14090	4.9%

---

*The Bridgeport District include only six towns of the eight-town Bridgeport Labork Market Area. Therefore, the figures above reflect 86% of the Bridgeport labor market information which approximately describes the employment contained within these six towns of the Bridgeport District. The Bridgeport District includes only seven towns of the fourteen-town Danbury Labor Market Area. Therefore, the figures above reflect 90% of the Danbury labor market information, which approximately describes the employment contained within these seven towns of the Bridgeport District. Data are from the Connecticut State Employment Service for the quarter ending June, 1968.

218. TOTAL NONAGRICULTURAL EMPLOYMENT

Bridgeport Area - June 1968

INDUSTRY	June 1968	May 1968	% Change June 1968 over May 1968	June 1967
Total Nonagricultural Employment	152,170	150,470	+ 0.5	146,770*
Manufacturing	78,830	78,650	+ 0.2	76,420*
Food	2,430	2,350	+ 3.4	2,200
Apparel	3,270	3,270	0.0	3,190
Printing & Publishing	1,840	1,830	+ 0.5	1,740
Rubber & Misc. Plastic Prod.	3,100	3,180	- 2.5	2,910
Stone, Clay and Glass	2,320	2,230	+ 4.0	1,820*
Primary Metals	5,590	5,420	+ 3.1	5,320
Fabricated Metals and Ordnance	12,090	12,060	+ 0.2	12,260
Machinery	8,050	8,370	- 3.8	8,560
Electrical Equipment	12,060	12,040	+ 0.2	11,290
Transportation Equipment	21,310	21,100	+ 1.0	20,330
Instruments	2,200	2,170	+ 1.4	2,270
**Other Manufacturing	4,570	4,630	- 1.3	4,530
Nonmanufacturing	73,340	71,820	+ 2.1	70,350*
Construction	5,950	5,430	+ 9.6	4,940*
Transportation (Inc. R.R.)	3,480	3,460	+ 0.6	3,560
Communications & Utilities	2,620	2,600	+ 0.8	2,620
Trade	26,440	25,960	+ 1.8	25,800
Wholesale	5,800	5,760	+ 0.7	5,860
Retail	20,640	20,200	+ 2.2	19,940
Finance Ins. & Real Estate	4,420	4,370	+ 1.1	4,310
Service (Inc. Nonprofit)	18,390	18,090	+ 1.7	17,120
Government	12,040	11,910	+ 1.1	12,000

*Excludes workers involved in labor-management disputes.

**Other manufacturing includes firms in the tobacco, lumber and wood, furniture and fixtures, paper, chemicals, paving and roofing materials, leather and miscellaneous manufacturing industries.

Unemployment - Bridgeport Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	8,000	4.6%	3,800	4,200
May	1968	6,700	4.0%	3,300	3,400
April	1968	6,600	3.9%	3,500	3,100
December	1967	6,300	3.7%	3,200	3,100
June	1967	5,400	3.3%	2,500	2,900

LABOR SUPPLY CLASSIFICATION
GROUP "C" MODERATE UNEMPLOYMENT
AS DESIGNATED BY THE U. S. DEPARTMENT OF LABOR

TOTAL NONAGRICULTURAL EMPLOYMENT

Danbury Area - June 1968

INDUSTRY	June 1968	March 1968	% Change June 1968 over March 1968	June 1967
Total Nonagricultural Employment	36,600	34,650	+ 5.6	34,810**
Manufacturing	14,660	14,300	+ 2.5	14,090**
Apparel	690	660	+ 4.5	640
Hats	370	350	+ 5.7	310
Furniture and Paper	1,170	1,140	+ 2.6	1,170
Fabricated Metals	1,290	1,350	- 4.4	1,320
Machinery	2,390	2,300	+ 3.9	2,520
Electrical Equipment	3,480	3,440	+ 1.2	3,060
Instruments	2,200	2,180	+ 0.9	1,870
*Other Manufacturing	3,440	3,230	+ 6.5	3,510**
Nonmanufacturing	21,940	20,350	+ 7.8	20,720**
Construction	1,920	1,270	+51.2	1,820**
Transportation (Incl. R.R.)	870	850	+ 2.4	910
Communications & Utilities	700	660	+ 6.1	690
Trade	6,910	6,350	+ 8.8	6,460
Wholesale	660	620	+ 6.4	680
Retail	6,250	5,730	+ 9.1	5,780
Finance, Ins. & R. E.	960	940	+ 2.1	970
Service (Incl. Nonprofit)	4,980	4,630	+ 7.6	4,660
Government	5,600	5,650	- 0.9	5,210

*Other manufacturing includes firms in the food, textiles, lumber and wood products, printing and publishing, chemicals, petroleum refining, rubber, leather, stone, clay and glass, primary metals, transportation equipment and miscellaneous manufacturing industries.
**Excludes worker idled due to labor-management disputes.

Unemployment - Danbury Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	1,900	4.4%	780	1,120
May	1968	1,400	3.4	880	520
April	1968	1,500	3.7	1,030	470
March	1968	1,700	4.4	1,270	430
December	1967	1,400	3.6	760	640
June	1967	1,900	4.7	910	990

TOTAL NONAGRICULTURAL EMPLOYMENT

Norwalk Area - June, 1968

INDUSTRY	June 1968	March 1968	% Change June 1968 over Mar. 1968	June 1968
Total Nonagricultural Employment	45,760	44,270	+ 3.4	44,920**
Manufacturing	20,720	21,090	- 1.8	21,240**
Food	920	870	+ 5.7	860
Textiles	560	540	+ 3.7	610
Apparel	1,290	1,360	- 5.1	1,200
Printing & Publishing	1,160	1,190	- 2.5	1,120
Chemicals	320	250	+28.0	510
Leather	1,210	1,330	- 9.0	1,300
Fabricated Metals	800	1,100	-27.3	1,060
Machinery	1,480	1,480	0.0	1,410
Electrical Equipment	6,450	6,650	- 3.0	7,180
Instruments	4,270	4,090	+ 4.4	3,880
*Other Manufacturing	2,260	2,230	+ 1.3	2,110**
Nonmanufacturing	25,040	23,180	+ 8.0	23,680**
Construction	1,990	1,570	+26.8	1,970**
Transportation (Inc. R.R.)	830	780	+ 6.4	810
Communications & Utilities	810	810	0.0	800
Trade	8,170	7,570	+ 7.9	7,830
Wholesale	1,070	1,060	+ 0.9	1,020
Retail	7,100	6,510	+ 9.1	6,810
Finance, Insurance & R.E.	980	920	+ 6.5	920
Service	7,210	6,640	+ 8.6	6,700
Government	5,050	4,890	+ 3.3	4,650

*Other manufacturing includes lumber and wood, furniture, rubber, stone, clay and glass, primary metals and other minor groups.

**Excludes workers idled in a labor-management dispute.

Unemployment - Norwalk Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	2,300	4.2%	1,800	500
May	1968	1,700	3.3	1,040	660
April	1968	1,600	3.0	1,150	450
March	1968	1,500	2.9	1,150	350
December	1967	1,800	3.3	1,210	590
June	1967	2,100	3.9	1,220	880

TOTAL NONAGRICULTURAL EMPLOYMENT

Stamford Area - June, 1968

INDUSTRY	June 1968	May 1968	% Change June 1968 over May 1968	June 1967
Total Nonagricultural Employment	76,180**	74,590**	+ 2.1	74,180**
Manufacturing	26,330**	26,350**	- 0.1	25,810
Food	1,550	1,540	+ 0.6	1,550
Textiles & Apparel	610	600	+ 1.7	640
Printing & Publishing	2,570	2,640	- 2.7	2,530
Chemicals	2,780	2,730	+ 1.8	2,710
Fabricated Metals	1,040	1,040	0.0	1,030
Machinery	7,860	7,780	+ 1.0	7,680
*Other Manufacturing	4,330**	4,410**	- 1.8	4,540
Nonmanufacturing	49,850**	48,240**	+ 3.3	48,370**
Construction	3,940	3,430**	+14.9	3,840**
Transportation (Incl. R.R.)	1,590	1,520	+ 4.6	1,540
Communications & Utilities	1,200**	1,350	-11.1	1,330
Trade	16,250	15,820	+ 2.7	16,090
Wholesale	2,560	2,440	+ 4.9	2,500
Retail	13,690	13,380	+ 2.3	13,590
Finance, Ins. & Real Estate	3,570	3,480	+ 2.6	3,310
Service (Incl. Nonprofit)	15,970	15,320	+ 4.2	15,020
Government	7,330	7,320	+ 0.1	7,240

*Other manufacturing includes firms in the lumber, furniture, paper, petroleum products, rubber, stone, clay and glass, primary metals, transportation equipment, instruments and watches, and miscellaneous manufacturing industries.

**Excludes workers idled in labor-management disputes.

Unemployment - Stamford Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	3,200	3.5%	1,900	1,300
May	1968	2,500	2.8	1,650	850
April	1968	2,400	2.7	1,620	780
December	1967	2,900	3.3	1,900	1,000
June	1967	3,500	3.9	2,100	1,400

Labor Supply Classification
Group "B" Low Unemployment
As Designated by the U.S. Department of Labor

V. Educational and Health Resource

A. Educational Resource[10]

1. Accredited Institutions of Higher Education
    - a) Public Junior Colleges
        1) Norwalk Community College........................Norwalk
        2) Norwalk St. Technical College Center.............Norwalk
        3) University of Connecticut Branch.................Stamford
        4) Housatonic Community College.....................Stratford
    - b) Private Junior Colleges
        1) Junior College of Conn., U. of Bridgeport........Bridgeport
        2) Silvermine College of Art........................New Canaan
    - c) Public College
        1) Western Connecticut State College................Danbury
    - d) Private Colleges and Universities
        1) Bridgeport Engineering Institute.................Bridgeport
        2) College of Notre Dame............................Wilton
        3) Fairfield University.............................Fairfield
        4) Sacred Heart University..........................Bridgeport
        5) St. Basil's College..............................Stamford
        6) St. Mary's Seminary..............................Norwalk
        7) University of Bridgeport.........................Bridgeport
2. Private Schools for Special Occupational Training
    - a) Butler Business School.............................Bridgeport
    - b) Colonial School of Tool Design.....................Monroe
    - c) Famous Schools, Inc................................Westport
    - d) Lee Johnson School of Business.....................S. Norwalk
    - e) Merrill Business Schools, Inc......................Stamford
    - f) Short's Secretarial School.........................Stamford
    - g) Warren Business Institute..........................Bridgeport
    - h) Warren Institute Technical School..................Bridgeport
3. State Regional Vocational Technical Schools
    - a) Bullard-Havens Regional Voc.-Tech. School..........Bridgeport
    - b) Henry Abbott Regional Voc.-Tech. School............Danbury
    - c) J. M. Wright Regional Voc.-Tech. School............Stamford
4. State-aided School for the Disabled
    - a) Bridgeport Regional Center.........................Bridgeport

---

[10] Connecticut State Department of Education, Educational Directory of Connecticut, 1967

PUBLIC SCHOOL SERVICES FOR EXCEPTIONAL CHILDREN[11]

BRIDGEPORT REGION

TOWN	Learning Disabilities	Mental Retardation	Emotionally Disturbed	Physically Handicapped	Speech & Hearing	Gifted & Talented	Perceptually & Neurologically Impaired	Legally Blind & Partially Sighted	Social Work Services	Psychological Services
1. Bethel		x	x			x				x
2. Bridgeport		x	x	x	x	x	x	x	x	x
3. Brookfield		x								x
4. Danbury		x			x	x			x	
5. Darien		x	x		x	x		x		x
6. Easton	x	x	x				x			x
7. Fairfield	x	x	x		x	x	x	x	x	x
8. Greenwich	x	x	x		x	x		x	x	x
9. Monroe		x			x					
10. New Canaan	x	x			x	x			x	x
11. New Fairfield	x	x					x			x
12. Newtown	x	x			x					x
13. Norwalk	x	x	x		x	x	x	x	x	x
14. Redding	x	x	x			x	x			x
15. Ridgefield		x			x	x		x	x	x
16. Stamford		x	x		x	x	x	x	x	x
17. Stratford		x		x	x				x	x
18. Trumbull		x	x		x	x	x		x	x
19. Weston		x								
20. Westport		x			x	x		x	x	x
21. Wilton	x	x			x	x			x	x

---

[11] Connecticut State Department of Education, Bureau of Pupil Personnel and Special Education Services, Directory of Public School Services to Exceptional Children, 1967-1968.

B. Health Resources[12]

1. Locally Administered Hospitals

a) Bridgeport Hospital....................................Bridgeport
b) Danbury Hospital.......................................Danbury
c) Greenwich Hospital Association.........................Greenwich
d) The Nathaniel Witherell Hospital.......................Greenwich
e) Norwalk Hospital.......................................Norwalk
f) The Park City Hospital.................................Bridgeport
g) St. Joseph's Hospital..................................Stamford
h) St. Vincent's Hospital.................................Bridgeport
i) The Stamford Hospital..................................Stamford

2. Licensed Private Mental Hospitals

a) Hall-Brooke Hospital...................................Westport
b) Silver Hill Foundation.................................New Canaan
c) Westport Sanitarium....................................Westport

3. Public Mental Hospital

a) Fairfield Hills Hospital...............................Newtown

4. Public Tuberculosis Hospital

a) Laurel Heights Hospital...............................Shelton

---

[12] State of Connecticut, Register and Manual, revised, 1966

VI. Population Data[13]

As indicated in the following tables, the Bridgeport District is expected to add approximately 140,000 people to its current population by 1975*. This estimated increment, rough as it is, still gives a good indication of the growth to be expected in this district. As the general population increases, the disabled population also increases, and their needs for social and rehabilitation services will rise at a predictable rate.

It may be important to note that the population growth in the Danbury area is the largest of any area in Connecticut and that its rate of growth is more than twice the rate of increase for the state as a whole. Danbury and the surrounding suburban towns are expected to continue to experience population growth. A substantial part of the growth will result from people moving into the area from the densely populated areas of New York City, Stamford, Norwalk, and Bridgeport. The city of Bridgeport has experienced a population decrease and this decreasing trend is expected to continue.

*Method of Population Projection

The estimates (for 1970 and 1975) indicated on the following table do not take into account such variables as birth and death rates, changes in migration patterns, or fluctuations in employment opportunities. They are based on figures provided by the Connecticut State Department of Health and these data were treated in the following manner:

1. 1960 population was subtracted from the 1966 population.
2. This six-year population increase (or decrease) was divided by six to obtain the average annual increment (or decrement).
3. The average annual increment was multiplied by four and added to the 1966 population to estimate the 1970 population.
4. The average annual increment was multiplied by nine and added to the 1966 population to estimate the 1975 population.

NOTE: This is purely a linear projection.

---

[13] Connecticut, Cooperative Area Manpower Planning; Also: Hartford National Profiles.

POPULATION DATA[14]

BRIDGEPORT DISTRICT

COUNTY	TOWN	1960	1965	1970	1975
Fairfield	Bethel	8200	9500	11000	12450
	Bridgeport	156748	155300	152200	150000
	Brookfield	3500	6500	9500	9800
	Danbury	39600	46100	51430	57350
	Darien	18600	20900	22930	26000
	Easton	3400	4400	5570	6650
	Fairfield	46500	53000	59670	66250
	Greenwich	53700	60200	67000	73700
	Monroe	6500	8800	11000	13250
	New Canaan	13600	18000	22600	27100
	New Fairfield	3400	4400	6400	7900
	Newtown	11373	14000	17200	20070
	Norwalk	68100	74800	79765	85600
	Redding	3400	4800	6565	8150
	Ridgefield	8300	13800	18130	23050
	Stamford	93200	102800	113365	123450
	Stratford	44900	45000	45000	45000
	Trumbull	20500	25100	31500	37000
	Weston	4100	5700	7430	9100
	Westport	21200	26400	32700	38450
	Wilton	8100	11000	14600	17850

District Totals

District	Towns				
Bridgeport	21	636,921	710,500	785,555	858,170

---

[14] Hartford National, *Economic Profiles*.

VII. Social Agency Offices in the Bridgeport District[15]

A. Public Agencies

1.	Connecticut State Employment (Local Offices)	Bridgeport Danbury Norwalk Stamford
2.	Office of Economic Opportunity Agencies	
	a) Action for Bridgeport Community Development	Bridgeport
	b) Committee on Training and Employment	Stamford
	c) Community Action Committee	Danbury
	d) Community Renewal Team	Stamford
	e) Norwalk Economic Opportunity, NOW	Norwalk
3.	State Department of Health (District Office)	Danbury
	Division of Vocational Rehabilitation (Local Offices)	Danbury Norwalk Stamford
4.	State Department of Health Crippled Children Section (Monthly Clinics)	Danbury Stamford
5.	State Department of Health Office of Mental Retardation (Regional Center)	Bridgeport
6.	State Department of Health Office of TB Control (Out-patient services)	Danbury Greenwich Newtown Norwalk Stamford Trumbull
7.	State Department of Mental Health (Alcoholism Clinics)	Bridgeport Stamford
8.	TB Clinic (City of Bridgeport)	Bridgeport
9.	Veterans' Administration Office and Clinic	Bridgeport

---

[15] R.W. Bain (ed.), *Directory of Rehabilitation Resources in Connecticut*, 1966; Also: Connecticut, *Register and Manual*.

B. Private Agencies

1.	American Cancer Society		Bridgeport Danbury Greenwich Norwalk
2.	The Arthritis Foundation	(Bridgeport Hosp. Clinic) (Greenwich Hosp. Clinic)	Bridgeport Greenwich
3.	Children's Services of Connecticut (District Offices)		Danbury Norwalk
4.	Connecticut Association for Mental Health	(Stamford-Darien area)	Bridgeport Norwalk Stamford
5.	Connecticut Association for Retarded Children		Bridgeport Danbury Newtown Norwalk Stamford Ridgefield
6.	Connecticut Heart Association		Bridgeport Danbury Greenwich Norwalk Stamford
7.	Connecticut Society for Crippled Children and Adults	(Easter Seal Camp)	Bridgeport Stamford Trumbull
8.	Connecticut TB and Health Association		Bridgeport Norwalk Stamford
9.	Goodwill Industries	(Local Plants)	Bridgeport Danbury South Norwalk Stamford Westport
10.	Muscular Dystrophy Association	(Danbury Hosp. Clinic)	Danbury

Private agencies cont............

11.	National Foundation for Diseases of the Central Nervous System	Bridgeport
12.	National Multiple Sclerosis Society	Darien
13.	Speech and Hearing Clinic, Inc.	Bridgeport

FINAL REPORT
OF
BRIDGEPORT REGIONAL COMMITTEE
EDMUND S. MCLAUGHLIN
CHAIRMAN

In our deliberations in the Regional Study Committee of the Statewide Planning program, several items were consistently discussed in our sessions.

The following are our recommendations:

1. It is recommended that the Division of Vocational Rehabilitation establish minimum acceptable standards for personnel and services being supported by DVR in the State of Connecticut.

   The standards for personnel should be further developed in cooperation with representatives from each state professional society that has members who provide services to DVR clients.

   It is recognized that this has been done to some extent (but not completely), with such key personnel as psychologists and physicians, and even to a lesser degree, standards have been established for a number of other professions allied to medicine. In addition, some attempt sould be made to investigate the necessity - or lack of necessity - for establishing minimal qualifications for workers in programs supported by DVR.

   In establishing standards for services, one might consider the employee-client ratio, the minimum number of people representing specific professions who should be staffing certain DVR supported programs, and the non-professional to professional ratio in programs where this balance might be important. Any other factors that have been found to be critical to effective workshop performance (such as available facilities), should also be considered.

2. Concern exists with respect to the availability of funds. The fact of adding more staff does not necessarily mean that any more service is going to be offered; because a concomitant of additional staff, certainly, is additional funds for the staff to spend for the needs of their particular clients.

3. This also applies to the extension of new areas where there are disabling conditions, rather than making sure that the traditional handicaps have been adequately cared for.

4. To assure rehabilitation services being rendered to those physically, mentally, and emotionally impaired and disabled, to whom traditionally the State Rehabilitation Agency has had a commitment and for whom it is the only resource open, it is recommended that the Vocational Rehabilitation Services Plan retain a distinctive emphasis on the vocational aspects of medically definable disabling conditions.

To obtain maximum benefits from public funds appropriated to the State Rehabilitation Agency for Vocational Rehabilitation of the disabled, maximum eligibility criteria should be adopted which considers:

a. an upper age limit, that at which Medicare begins.
b. medical definitions of disability.
c. handicapping effects of disability on employment or vocational training.
d. the degree of serverity of the disability acceptable.

It is further recommended that the Vocational Rehabilitation Services Plan reflect the existence of other state case serving agencies which can be utilized in the obtainment of rehabilitative services for those to whom they have a primary responsibility, as specified by law. Concern is over broadening of the DVR's responsibilities to serve those who are already being served by a State or municipal agency; and the enactment of legislation providing for staff orientation and training to deal effectively with handicapping conditions other than those that have generally been considered by the DVR.

It would appear that bringing non-medically disabling conditions under the DVR would lead to duplication of services and an over-extension of the DVR personnel and case service funds. It is felt that rehabilitation - its philosophy and goals - would be more greatly advanced and strengthened through application of its principles in: the rehabilitation of second offenders by penal department personnel; helping drug addicts through Narcotics Bureau Rehabilitation programs. On the other hand, school special services departments programs for disabled children should be continued and strengthened; underemployed persons rehabilitated by Labor Department and Employment Service programs; and the problems of old age met through Medicare and Welfare Department rehabilitation programs.

5. Concern exists over the breadth of the present definition of "disability" and "eligibility", and the ability (financial and staff-wise) of DVR to service adequately the traditionally handicapped person in its effort to take on such a huge program through the broadened definitions.

Also, limits should be considered for setting the maximum age of the DVR client; many older people with little or nor vocational goal are eligible for needed help through other State-Federal programs.

6. Suggestion that an open end budget be made available to the Division of Vocational Rehabilitation.

   This does not mean, however, that the standards required for counselors be lost in the desire to meet the needs of many more persons.

   These standareds must be reviewed and the criteria of selection must be evaluated so that the counselors who are brought into the picture to handle the varieties of groups of persons with disabling conditions will be treated with a competence and understanding of the particular problems.

   Presently there seems to be a closed end budget with an open end eligibility. There should be some resolution of this cycle.

These deliberations were of consequence and, it is hoped, determine the future paths that will be taken with respect to the Division of Vocational Rehabilitation in the State of Connecticut.

BRIDGEPORT REGIONAL COMMITTEE

CHAIRMAN

EDMUND MCLAUGHLIN
EXECUTIVE DIRECTOR

REHABILITATION CENTER OF EASTERN FAIRFIELD, BRIDGEPORT

James Adair
Goodwill Industries, Bridgeport

Warren C. Bower, Ph.D.
Meridan

Mrs. Lillian Craig, Youth Opportunity
Office, Labor Department

H. Philip Dinan, Jr., M.D.
Administrator
Office of Humane Affairs

Harold E. Johnson, Jr., V.R.
Supervisor
Division of Vocational Rehabilitation

Mrs. Edna Jones, Wilton

Mrs. Karen Kagey, Executive Director
Society to Advance Retarded
Center, Norwalk

Mrs. Charlotte Kaufman, Executive
Director
Family Life Film Center of
Connecticut, Fairfield University

Paul Lane, Ph.D. Director
H.P. Dinan Evaluation Center

J. Leonard Lyons, Vocational Rehabilitation
Supervisor, Bridgeport

Paul Littlefield, Assistant Director
Aid to Retarded Children, Stamford

William Metzger, Director
Danbury Association to Advance
Retarded

Miss Ruby Oscarson, Director
Rehabilitation Center of Southern
Fairfield County, Stamford

Louise Soares, Ph.D.
University of Bridgeport

Mrs. E.B. Thompson
Action Bridgeport Community
Development

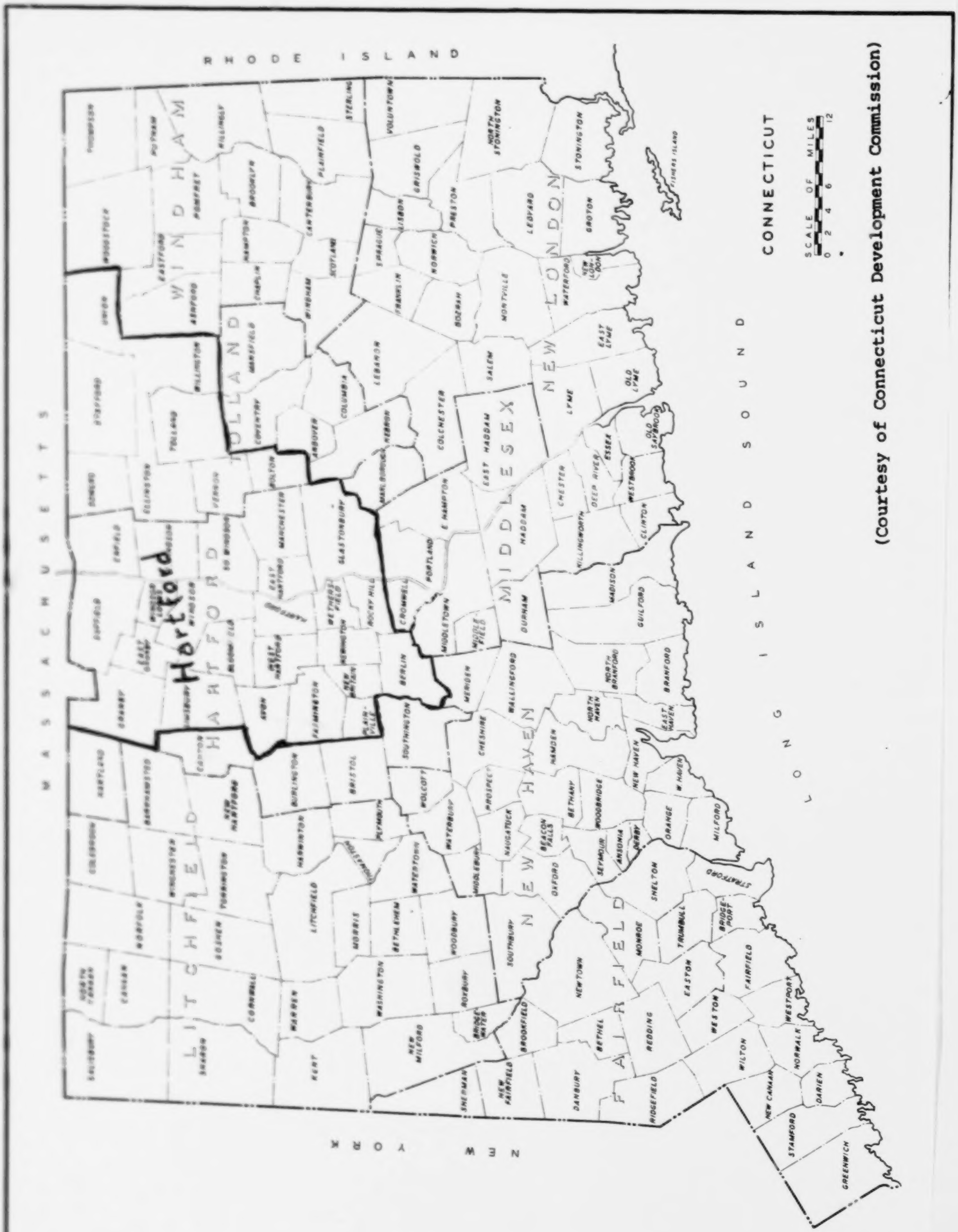
Mrs. Sylvia Trachtenberg, Counselor,
DVR, Central High School

George Trent, District Supervisor
DVR, Bridgeport

Ralph Welsh, Ph.D.
Bridgeport

Hugh Wentworth
Community Council, Stamford

Ansley Whatley, Director of Workshop
Society to Advance Retarded Center
Norwalk


RHODE ISLAND
MASSACHUSETTS
NEW YORK
LONG ISLAND SOUND
CONNECTICUT
SCALE OF MILES
0 2 4 6 12
Hartford
HARTFORD
TOLLAND
WINDHAM
NEW LONDON
MIDDLESEX
NEW HAVEN
FAIRFIELD
LITCHFIELD
THOMPSON
PUTNAM
KILLINGLY
STERLING
VOLUNTOWN
NORTH STONINGTON
STONINGTON
FISHERS ISLAND
WOODSTOCK
POMFRET
BROOKLYN
PLAINFIELD
GRISWOLD
PRESTON
LEDYARD
GROTON
EASTFORD
HAMPTON
CANTERBURY
SPRAGUE
LISBON
NORWICH
NEW LONDON
WATERFORD
UNION
ASHFORD
CHAPLIN
SCOTLAND
WINDHAM
FRANKLIN
BOZRAH
MONTVILLE
MANSFIELD
LEBANON
SALEM
EAST LYME
WILLINGTON
STAFFORD
TOLLAND
COVENTRY
COLUMBIA
COLCHESTER
OLD LYME
LYME
EAST HADDAM
ANDOVER
HEBRON
SOMERS
ELLINGTON
VERNON
BOLTON
MARLBOROUGH
EAST HAMPTON
CHESTER
ESSEX
OLD SAYBROOK
DEEP RIVER
WESTBROOK
ENFIELD
SO WINDSOR
MANCHESTER
GLASTONBURY
PORTLAND
HADDAM
KILLINGWORTH
CLINTON
SUFFIELD
WINDSOR LOCKS
WINDSOR
EAST HARTFORD
HARTFORD
WETHERSFIELD
ROCKY HILL
CROMWELL
MIDDLETOWN
MIDDLEFIELD
DURHAM
MADISON
GUILFORD
EAST GRANBY
BLOOMFIELD
WEST HARTFORD
NEWINGTON
BERLIN
MERIDEN
WALLINGFORD
NORTH BRANFORD
BRANFORD
GRANBY
SIMSBURY
AVON
FARMINGTON
NEW BRITAIN
PLAINVILLE
SOUTHINGTON
CHESHIRE
HAMDEN
NORTH HAVEN
EAST HAVEN
HARTLAND
BARKHAMSTED
CANTON
BURLINGTON
BRISTOL
WOLCOTT
PROSPECT
BETHANY
WOODBRIDGE
NEW HAVEN
W HAVEN
COLEBROOK
NEW HARTFORD
HARWINTON
PLYMOUTH
WATERBURY
NAUGATUCK
BEACON FALLS
SEYMOUR
ANSONIA
DERBY
ORANGE
MILFORD
WINCHESTER
TORRINGTON
THOMASTON
WATERTOWN
MIDDLEBURY
OXFORD
SHELTON
STRATFORD
NORFOLK
GOSHEN
LITCHFIELD
MORRIS
BETHLEHEM
WOODBURY
SOUTHBURY
MONROE
TRUMBULL
BRIDGEPORT
NORTH CANAAN
CANAAN
CORNWALL
WARREN
WASHINGTON
ROXBURY
NEWTOWN
EASTON
FAIRFIELD
SALISBURY
SHARON
KENT
NEW MILFORD
BRIDGEWATER
BROOKFIELD
BETHEL
REDDING
WESTON
WESTPORT
SHERMAN
NEW FAIRFIELD
DANBURY
RIDGEFIELD
WILTON
NORWALK
NEW CANAAN
DARIEN
STAMFORD
GREENWICH

(Courtesy of Connecticut Development Commission)

[1] Map of Hartford Region

PROFILE OF HARTFORD REGION

I. Rationale for Districting

A. The area is topographically and economically homogeneous. Most of the residents of this area work within the cities and towns of the Hartford District, although some residents in the northern and northeastern sections find employment in Massachusetts (particulary around Springfield) and in the Norwich District.[2]

B. Sub-divisions of this district are frequently taken together as intra-state regions for other planning purposes.

II. Transportation Patterns[3]

The traffic pattern in the Hartford District may be compared to a spoked wheel with the city of Hartford as the hub. Although the major traffic flow is concentrated on Interstate Highways 84 and 91, U.S. 44, 6 and 202, and Connecticut Highways 2, 4, 9, 10, and 17, are heavily traveled and essential to the transportation flow of the district.

Most of the inter-state travel which passes through Connecticut follows the highways which cut through the city of Hartford. Although new expressway construction has limited the volume of inter-state traffic that actually stops in the city, the economy of the sourrounding area is assisted by the traffic which calls on local restaurants, gas stations, and motels for service.

Hartford and the surrounding towns (including New Britain) have a complex public transportation system. Buses are used more extensively by people in this area than in any other area of the state; however, the majority of residents use the automobile as a means of transportation to work. The outlying areas of the district are not as well served by buses, but the need for bus transportation in these areas is not as intensive. The number of work trips by bus is expected to increase at a fairly rapid rate for the Hartford area in the next few years.

III. Topography[4]

The Hartford District occupies both the upper half of the geographical region known as the Central Lowlands, and the northwestern part of the geographical region known as the Eastern Uplands. The Central Lowlands, which is bisected by the Connecticut River, separates the rugged Western Uplands from the rolling Eastern Uplands. This area contains the heaviest concentration of fertile soils in the state, and is the home of the Connecticut tobacco crop, but much of the good farm land is being developed for suburban and industrial use.

---

[2] Connecticut Labor Department, Employment Security Division, Commuting Patterns in Connecticut, June, 1966.

[3] State of Connecticut, Connecticut Interregional Planning Program, Transportation, "Connecticut: Choices for Action;" 1966.

[4] State of Connecticut, Connecticut Interregional Planning Program, Connecticut Development Commission, Connecticut Takes Stock for Action, June, 1964

The rolling Eastern Uplands is densely wooded and interspersed with many small lakes and ponds. The area surrounding Hartford is also being developed for suburban and industrial use. This development is a reaction to the acute shortage of private housing units within commuting distance of Hartford. The northeastern corner of the Hartford District is much more rural in nature, and is geographically more like the Norwich District than it is like the Hartford District.

IV. Economic Data[5]

The majority of the employees in the Hartford District work in non-manufacturing. Most employees of the central offices of the State's various departments work in Hartford, and this city is also the home of many of the larger insurance companies; therefore, the average educational level of the Hartford workers is higher than would be the average for other parts of the State.

Unemployment is typically low, and most of the unemployed are under-educated and unskilled. The employment opportunity outlook for the two labor market areas in the Hartford District is good for skilled and professional workers. The demand for unskilled labor will continue to decrease.

LABOR MARKET INFORMATION

Area		Non-Agricultural Employment		
	Mfg.	Non-mfg.	Gov't.	Total
Hartford District Totals	139250	178260	37140	354650

		Unemployment	
Men	Women	Total	Ratio
8090	6910	15000	4.0%

---

[5] Connecticut State Employment Service, Bureau of Labor Statistics, Also: Connecticut Labor Department, Cooperative Area Manpower Planning System Report.

TOTAL NONAGRICULTURAL EMPLOYMENT

Hartford Area - June 1968

INDUSTRY	June 1968	May 1968	% Change June 1968 over May 1968	June 1967
Total Nonagricultural Employment	307,970**	305,680**	+ 0.7	299,070**
Manufacturing	114,030**	113,920**	+ 0.1	113,880**
Food	4,190	4,090	+ 2.4	4,100
Textiles & Apparel	4,580**	4,470**	+ 2.5	4,600**
Furniture, Wood and Paper	2,960	2,960	0.0	2,890
Printing & Publishing	3,800	3,830	- 0.8	3,860
Chemicals, Rubber & Misc. Plastic Products	1,720	1,620	+ 6.2	1,490
Primary Metals	1,080	1,070	+ 0.9	1,020**
Fabricated Metals & Aircraft	63,350	63,780	- 0.7	62,940
Machinery	20,540**	20,480**	+ 0.3	20,980
Industrial	12,960**	12,940**	+ 0.2	13,310
Office & Service	7,580	7,540	+ 0.5	7,670
Electrical Equipment	5,120	5,110	+ 0.2	5,790
Measuring & Controlling Devices	2,210	2,100	+ 5.2	2,100
*Other Manufacturing	4,480	4,410	+ 1.6	4,110**
Nonmanufacturing	193,940**	191,760	+ 1.1	185,190**
Construction	13,890	13,420	+ 3.5	13,280**
Transportation (Inc. R.R.)	5,850	5,790	+ 1.0	5,730
Communications & Utilities	5,020	4,900	+ 2.4	4,760
Trade	58,300	57,660	+ 1.1	55,470
Wholesale	14,170	14,070	+ 0.7	13,230
Retail	44,130	43,590	+ 1.2	42,240
Finance & Real Estate	7,900	7,780	+ 1.5	7,650
Insurance	29,950**	30,070	- 0.4	28,350
Service (Inc. Nonprofit)	39,930	39,470	+ 1.2	38,350
Government	33,100	32,670	+ 1.3	31,600

*Other manufacturing includes firms in the ordnance, tobacco, leather, stone, clay and glass, brush and miscellaneous manufacturing industries.

**Excludes workers idled by labor-management disputes.

Unemployment - Hartford Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	12,600	3.6%	7,000	5,600
May	1968	9,000	2.6	6,200	2,800
April	1968	8,700	2.6	5,500	3,200
December	1967	8,000	2.4	5,200	2,800
June	1967	11,200	3.3	6,400	4,800

LABOR SUPPLY CLASSIFICATION
GROUP "B" LOW UNEMPLOYMENT
AS DESIGNATED BY THE U.S. DEPARTMENT OF LABOR

TOTAL NONAGRICULTURAL EMPLOYMENT

New Britain Area - June 1968

INDUSTRY	June	May	% Change June 1968 over May 1968	June 1967
Total Nonagricultural Employment	46,680	45,820	+ 1.9	45,650**
Manufacturing	25,220	24,770	+ 1.8	25,580**
Hardware	6,980	6,710	+ 4.0	6,890
Primary & Fabricated Metals	3,920	3,930	- 0.3	3,840
Machinery	2,860	2,810	+ 1.8	2,840
Bearings	5,250	5,250	0.0	5,420
Electrical Equipment	2,500	2,500	0.0	2,870
*Other Manufacturing	3,710	3,570	+ 3.9	3,720**
Nonmanufacturing	21,460	21,050	+ 1.9	20,070**
Construction	2,080	1,860	+11.8	1,480**
Transportation (Inc. R.R.)	800	740	+ 8.1	850
Communications & Utilities	1,080	1,060	+ 1.9	1,160
Trade	7,600	7,500	+ 1.3	7,350
Wholesale	990	970	+ 2.1	920
Retail	6,610	6,530	+ 1.2	6,430
Finance, Ins. & Real Estate	1,120	1,100	+ 1.8	1,010
Service (Inc. Nonprofit)	7,740	4,640	+ 2.2	4,450
Government	4,040	4,150	- 2.7	3,770

*Other manufacturing includes firms in the food, apparel, lumber and wood, furniture and fixtures, paper, printing, chemicals, stone, clay and glass, transportation equipment, photographic and sporting equipment, and slide fastener and other miscellaneous manufacturing industries.

**Excludes workers idled due to labor-management disputes.

Unemployment - New Britain Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	2,400	4.6%	1,090	1,310
May	1968	2,300	4.5	960	1,340
April	1968	2,400	4.6	1,090	1,310
December	1967	1,700	3.4	920	780
June	1967	2,000	3.8	1,140	860

LABOR SUPPLY CLASSIFICATION
GROUP "C" MODERATE UNEMPLOYMENT
AS DESIGNATED BY THE U.S. DEPARTMENT OF LABOR

V. Educational and Health Resources

A. Educational Resources[6]

1. Accredited Institutions of Higher Education

a) Public Junior Colleges

1)	Hartford State Tech. College Center	Hartford
2)	Manchester Community College	Manchester
3)	Greater Hartford Community College	Hartford

b) Private Junior Colleges

1)	Hartford College for Women	Hartford
2)	Holy Family Seminary	West Hartford
3)	Our Lady of the Angels	Enfield
4)	St. Thomas Seminary	Bloomfield

c) Public College

1)	Central Connecticut State College	New Britain

d) Private Colleges

1)	Diocesan Sisters College	Hartford
2)	Diocesan Sisters College, Branch	West Hartford
3)	Hartford Seminary Foundation	Hartford
4)	Rensselaer Polytechnic Institute	South Windsor
5)	St. Alphonsus College	Suffield
6)	St. Joseph College	West Hartford
7)	Trinity College	Hartford
8)	University of Hartford	West Hartford

2. Private Schools for Special Occupational Training

a)	Electronic Computer Programmer Institute	Hartford
b)	Hartford Institute of Accounting	Hartford
c)	Hartford Secretarial School	Hartford
d)	Mary Ward Secretarial School	Hartford
e)	Moody School of Commerce	New Britain
f)	Morse College	Hartford
g)	New England Technical Institute of Conn	New Britain
h)	Porter School of Engineering Design	Rocky Hill

3. State Regional Vocational-Technical Schools

a)	A.I. Prince Regional Voc.-Tech. School	Hartford
b)	Howell Cheney Regional Voc.-Tech. School	Manchester
c)	E.C. Goodwin Regional Voc.-Tech. School	New Britain

4. State-aided Schools for the Disabled

a)	American School for the Deaf	West Hartford
b)	Connecticut Institute for the Blind	Hartford
c)	Greater Hartford Regional Center	Newington
d)	Newington Hospital for Crippled Children	Newington
e)	State Receiving and Study Home	Warehouse Pt.

---

[6] Connecticut State Department of Education, Educational Directory of Connecticut, 1967.

PUBLIC SCHOOL SERVICES FOR EXCEPTIONAL CHILDREN[7]

HARTFORD REGION

TOWN	Learning Disabilities	Mental Retardation	Emotionally Disturbed	Physically Handicapped	Speech & Hearing	Gifted & Talented	Perceptually & Neurologically Impaired	Legally Blind & Partially Sighted	Social Work Services	Psychological Services
1. Avon		x				x				x
2. Berlin		x			x		x		x	x
3. Bloomfield		x	x		x	x	x		x	x
4. Bolton		x							x	
5. East Granby	x	x							x	
6. East Hartford		x			x	x			x	x
7. East Windsor		x					x		x	
8. Ellington		x			x	x			x	
9. Enfield		x	x		x	x	x			x
10. Farmington		x			x	x				x
11. Glastonbury	x	x	x		x	x	x			x
12. Granby	x	x								
13. Hartford		x	x	x	x	x	x	x	x	x
14. Manchester		x		x	x	x	x		x	x
15. New Britain		x		x	x	x		x	x	x
16. Newington	x	x	x	x	x		x		x	x
17. Plainville	x	x						x	x	x
18. Rocky Hill		x			x		x			x
19. Simsbury		x			x	x				x
20. Somers		x							x	x
21. South Windsor	x	x	x			x				x
22. Stafford		x							x	
23. Suffield		x	x		x				x	x
24. Tolland		x							x	
25. Union									x	
26. Vernon		x			x		x		x	x
27. West Hartford		x	x	x	x		x	x		x
28. Wethersfield	x	x	x		x	x	x		x	x
29. Willington		x							x	
30. Windsor Locks	x	x							x	
31. Windsor		x	x		x	x	x		x	x

---

[7] Connecticut State Department of Education, Bureau of Pupil Personnel and Special Education Services, Directory of Public School Services to Exceptional Children, 1967-1968.

B. Health Resources[8]

1. Locally Administered Hospitals

a) Cyril and Julia Johnson Memorial Hospital...............Stafford
b) Hartford Hospital..Hartford
c) Manchester Memorial Hospital.............................Manchester
d) Mount Sinai Hospital.....................................Hartford
e) New Britain General Hospital.............................New Britain
f) New Britain Memorial Hospital............................New Britain
g) Rockville General Hospital...............................Vernon
h) St. Francis Hospital.....................................Hartford

2. Publically Administered Hospitals

a) McCook Hospital (In-patient psychiatric treatment fac.)..Hartford
b) Veterans' Administration Hospital........................Newington
c) Veterans' Home and Hospital..............................Rocky Hill

3. Licensed Private Mental Hospital

a) Institute of Living......................................Hartford

4. Public Mental Hospital

a) Blue Hills Hospital and Out-Patient Clinics..............Hartford

5. Public Tuberculosis Hospital

a) Cedarcrest Hospital......................................Newington

---

[8] State of Connecticut, Register and Manual, revised, 1966.

VI. Population Data[9]

As is indicated in the following tables, the Hartford District is to add 135,000 people to its current population by 1975.* This estimated increment, rough as it is, still gives a good indication of the growth to be expected in this district. As the general population increases, the disabled population also increases, and their needs for social and rehabilitation services will rise at a predictable rate.

Notice that the population of Hartford is expected to level off, while the surrounding suburban towns are expected to continue to experience a steady and continued growth.

The estimates for 1970 and 1975 indicated on the following table on the next page do not take into account such variables as birth and death rates, changes in migration patterns, or fluctuations in employment opportunities. They are based on figures provided by the Connecticut State Department of Health and these data were treated in the following manner:

1. 1960 population was subtracted from the 1966 population.
2. This six-year population increase (or decrease) was divided by six to obtain the average annual increment (or decrement).
3. The average annual increment was multiplied by four and added to the 1966 population to estimate the 1970 population.
4. The average annual increment was multiplied by nine and added to the 1966 population to estimate the 1975 population.

NOTE: This is purely a linear projection.

---

*Method of Population Projection

[9] Hartford National Bank and Trust Company, *Economic Profiles*, Hartford: 1967

POPULATION DATA
HARTFORD DISTRICT

COUNTY	TOWN	1960	1965	1970	1975
Hartford	Avon	5300	6900	8970	10800
	Berlin	11400	14100	16730	19400
	Bloomfield	13700	16500	20000	23200
	East Granby	2434	2800	3210	3600
	East Hartford	44200	48800	54200	59200
	East Windsor	7600	8500	9100	9850
	Enfield	31464	40828	47800	55975
	Farmington	10900	12400	13900	15400
	Glastonbury	14500	17100	19830	22500
	Granby	4968	5500	6020	6550
	Hartford	162178	162300	161000	161000
	Manchester	42200	45400	49870	53700
	New Britain	82200	88300	90700	94950
	Newington	17767	20397	24000	27100
	Plainville	13149	14800	16400	18000
	Rocky Hill	7416	3194	9160	10000
	Simsbury	10300	13800	16800	20000
	South Windsor	9700	14500	18200	22450
	Suffield	6779	7800	8600	9550
	West Hartford	62500	70100	75670	82200
	Wethersfield	20358	23300	27100	30450
	Windsor	19500	21100	22800	24500

COUNTY	TOWN	1960	1965	1970	1975
Hartford	Windsor Locks	11500	13300	15000	16750
Tolland	Bolton	3000	3400	4000	4500
	Ellington	5580	7200	8650	10200
	Somers	3702	4500	5370	6200
	Stafford	7476	7900	8000	8300
	Tolland	2950	4600	6500	8300
	Union	390	440	500	560
	Vernon	17100	20900	24400	28100
	Willington	2005	2300	2670	3000

District Totals

District	Towns				
Hartford	31	654,216	727,959	795,150	866,285

VII. Social Agency Offices in the Hartford District[10]

A. Public Agencies

1.	Connecticut State Employment (Local Offices)	Hartford (4) Manchester New Britain Thompsonville
2.	Office of Economic Opportunity Agencies	
	a) Community Renewal Program	New Britain
	b) Community Renewal Team	Hartford
	c) Neighborhood Community Action Programs	Hartford
	d) Office of Economic Opportunity (Local Office)	New Britain
3.	Social Adjustment Commission of the City of Hartford	Hartford
4.	State Board of Education for the Blind	Wethersfield
5.	State Department of Education (District Office)	Hartford
	Division of Vocational Rehabilitation (Local Office	New Britain
6.	State Department of Health Office of Mental Retardation (Regional Center)	Newington
7.	State Department of Health Office of TB Control (Out-Patient Services)	Hartford Manchester Newington
8.	State Department of Mental Health (Alcoholism Clinic)	Hartford
9.	State Department of Mental Health Child Guidance Clinic	Hartford
10.	TB Clinic (City of Hartford	Hartford
11.	TB Clinic (City of New Britain)	New Britain
12.	Veterans' Administration Regional Office	Hartford

---

[10] R.W. Bain (ed.), Directory of Rehabilitation Resources in Connecticut, 1966; Also: Connecticut, Register and Manual.

B. Private Agencies

1. American Cancer Society	Hartford Manchester New Britain
2. The Arthritis Foundation (Hartford Hospital Clinic) (Manchester Hospital Clinic)	Hartford Manchester
3. Cerebral Palsy Association	Hartford
4. Children's Services of Connecticut (Branch Office) (Children's Village) (Hartley-Salmon Guidance Clinic)	Manchester Hartford Hartford
5. Connecticut Association for Retarded Children	Avon Greenwich Hazardville Manchester New Britain Plainville West Hartford
6. Connecticut Heart Association	Hartford Manchester New Britain
7. Connecticut Institute for the Blind	Hartford
8. Connecticut Mental Health Association	Hartford Plainville
9. Connecticut Society for Crippled Children and Adults	Hartford
10. Connecticut TB and Health Association	Hartford New Britain
11. Muscular Dystrophy Association	Hartford
12. Cystic Fibrosis Association of Connecticut	Hartford
13. National Foundation for Diseases of the Central Nervous System	Hartford Stafford Sps.
14. National Multiple Sclerosis Society	Hartford

STATEWIDE PLANNING PROJECT
for
VOCATIONAL REHABILITATION SERVICES

HARTFORD REGIONAL COMMITTEE
INTER-AGENCY COMMUNICATIONS SUB-COMMITTEE

Cooperation, communication, and coordination have long been the goals of inter-agency relationships, but the effort to achieve them has not always been successful. The attempts, however, have resulted in a better understanding of the elements which effect the three C's. This report will attempt to pinpoint them, determine their effect, and offer some suggestions.

If we take the client as our point of reference, and follow him from the time that a service is perceived as needed, until rehabilitation has been completed, it may help to highlight the situation.

1. Awareness that a service is needed

This may occur in many ways: an individual may, himself, realize the need; or a member of the family; or a professional, such as a physician or minister; or a staff member of the agency involved. The environmental climate of awareness may very well determine the attitudes which people have toward their problems. If the agencies have worked together and have developed an environment in which people feel comfortable about having problems and seeking help, this may increase a person's willingness to recognize early symptoms and seek assistance. On the other hand, if a lack of communication, or long waiting lists, should exist, a barrier may be present between the public and the agencies offering services.

This involves individual and joint public relations programs. Agencies should inform the public of their policies and programs, in general, and work to create an atmosphere of openess and willingness to serve. Each agency, individually, could foster this awareness by having lay people on its policy-making committee develop more opportunities for volunteer service and publicize its activities. Thus, an atmosphere may be developed within the community which fosters an awareness that help is available when it is needed.

2. Motivating person to seek help

An awareness is not sufficient. The person must reach out to someone, or be reached out to. This involves the variety of services available in a community, their location, and the channels of communication which may be in existence. If the person is self-motivated, he will most likely approach a source with which he has had previous contact and feels comfortable. If not motivated, the person aware may have to provide stimulation, and may involve a network of agencies working together. Services that are neighborhood-based and in close proximity to other services perhaps provide the best motivation. In planning services, agencies may very well involve the consumers and other agencies, so that this proximity may be achieved. It may also be helpful to have neighborhood workers on staffs for contact and reaching out.

3. Determination of needed service.

This is a key factor in the whole process. The awareness that a service is needed may take the person to any one of a number of contacts. From there to the agency, or agencies, that can provide the best service, may be a long and difficult process. Previous agency contacts, background information from family, testing, case conferences, all can be helpful in determining the problem and the service needed. This involves the whole gamut of inter-agency cooperation from exchanging information to having a thorough understanding of roles, responsibilities, procedures, staff, etc.

Close working together is needed for this. Joint staff training, conferences, workshops, institutes, all are perhaps needed to develop the kind of professional trust that is necessary.

4. Providing needed service.

After evaluation, who does it? This may be one, or a number of agencies cooperating. Reports have to be maintained, which could be standardized as much as possible, information exchanged, confidentiality respected, and other referrals possibly made.

5. Evaluation of services.

Each agency should have some method of evaluating services offered. Satisfactory procedures for accomplishing this are still being sought. Subjective types of evaluation are the most common, as objective measures are not too productive. Good evaluation assists agencies in improving services, and forms the base for cooperation with other agencies in planning, developing, and providing services without duplication or overlapping.

6. Dissemination of knowledge.

Many research and demonstration projects are in operation today. The knowledge gained from these, however, is not disseminated in an orderly fashion. It is left to chance and the initiative of individuals, in large measure. More formal channels might to developed for an awareness of ongoing research and demonstration, and inter-agency communication developed for closer contacts between researcher and practitioner.

These, then, are the elements of continuity of care, and inter-agency cooperation, coordination, and communication. Attempts to achieve this can be on formal and informal bases, with the goal of providing a service from the time awareness develops until functioning is restored.

HARTFORD REGIONAL PLANNING PROJECT
for
VOCATIONAL REHABILITATION SERVICES

SUB-COMMITTEE ON REHABILITATION OF THE AGED

The Committee confined its consideration of the rehabilitation of the aged to those people over the age of sixty who needed some professional services to habilitate them physically, emotionally, or socially so that they might be self-sufficient. It also considered some preventative factors to maintain the aged at a level of healthy independence, thereby avoiding the future necessity for rehabilitation. Four areas of service were discussed: 1) the need for more beds in rehabilitation hospitals, plus physical therapists; 2) the need for more homemakers or health aides; 3) Day-Care Centers, plus transportation; and 4) proper diet, and medical and dental care.

1) Need for Rehabilitation Beds and Professional Services

It was thought that some hospitalized patients were remaining in a general hospital for a longer period of time than necessary, while waiting for beds in a rehabilitation hospital. These patients need daily physical or occupational therapy to maintain their level of mobility, which would be lost if they went to a convalescent hospital where physical therapy is usually offered twice a week, -- or three times, in some rare instances. (The shortage of trained personnel in physical or occupational therapy is a deterrent to good rehabilitation in a convalescent hospital.)

A sample study of patients referred by Saint Francis Hospital Social Service Department to a rehabilitation hospital (either Cedarcrest or Gaylord) was done for a period extending from April 1, 1967 to March 30, 1968. Of thirty-six patients referred, sixteen, or 44%, were over age sixty.

Waiting Period for Admission to Cedarcest or Gaylord

	Less than 1 wk.	1 wk.	1½	2	2½	3	3½	
Under 60 years	3	4	1	7	2	2	1	(1 readmission)
Over 60 years	1	7	1	2	1	2	0	(1 readmission)
Total	4	11	2	9	3	4	1	2

The table indicates that of the 36 patients of all ages, 13 patients had to wait one week or more, 12 patients waited two weeks or more, and 5 waited three weeks or more for admission to either Cedarcrest or Gaylord. These figures show the need for more rehabilitation beds to facilitate the transfer of rehabilitative patients out of general hospital beds that are needed for the treatment of the more acutely ill.

2) Need for Homemaker or Health Aides

With the advent of Medicare, there has been a greater tendency for patients to go to a convalescent hospital, rather than going home with supplementary services. Families, however, often ask if homemaker or home health aides are available so the patient can go home. Due to a shortage of personnel in this field, or residential ineligibility for service from Home Care, patients go to a convalescent hospital rather than home.

During a six-month period ending March 30, 1968, there were thirty-eight patients known to Saint Francis Hospital Social Service that probably would not have needed a convalescent hospital if a homemaker or home health aide service was available to them. Seven patients lived alone, while others had working family members unable to leave their jobs for a lengthy period. It should be noted that aged orthopedic patients sometimes do not have the same degree of recovery as younger orthopedic patients since they are more likely to have the complicating factor of arthritis, osteoporosis or other disability.

The homemaker service to the aged in the Greater Hartford area is supplied by 30 homemaker-housekeepers by Family Service, and is limited from three to nine hours per week for 171 clients each month. There are 35 home health aides serving the aged under the Medicare program. Last year, Family Service served 232 aged persons with homemaker service and 135 persons through the Meals-on-Wheels program.

Since there is a need for more homemakers, or health aides, the vast resource of retired persons could be utilized if the position were given status. A recent workshop on the aging brought out the fact that the reason for lack of interest in this service was not so much the low salary as the lack of status, which could be overcome by the wearing of a white uniform.

3) Day-Care Centers Needed

One worker at Family Service receives about two calls per week for a "baby-sitter" service for the aged. There is a frequent request for this type of service for patients being discharged from the hospital who are able to walk, but in need of supervision and companionship and not eligible for the Hartford Rehabilitation Center. Door-to-door transportation to a Day-Care Center would afford opportunities for socialization, good nutrition, and occupational therapy that would keep patients mobilized and prevent the loneliness and consequent depression of daily isolation. Presently, there is a pilot project in Hartford that will provide taxis for the elderly to clinics, doctors, etc., but this service should be on a permanent basis and be available in other areas.

4) Meals, Medical and Dental Care: Preventative Medicine

Recently, a gerontologist claimed that proper diet maintains vigor in the aged and stops the degenerative process. Many elderly people are admitted to the hospital for malnutrition and dehydration because they do not attempt to cook properly for themselves. There is a need for publicizing and increasing the existing services of Meals-on-Wheels, which can serve 64 people per day and 220 per year in the Hartford area. Only a small percentage of clients are not in the aged category. If a main kitchen were located in the Day-Care Center or in a housing project for the elderly, low cost meals could be provided on the premises, to take out, or to supply the Meals-on-Wheels program.

Since many of the aged have no dentures or are badly in need of dental care, they are not interested in the hard-to-chew, but necessary, foods for proper nutrition. A dental and medical clinic is needed to provide necessary care to prevent debilitation. Family Service and the Hartford Health Department had a dental and diagnostic clinic on a pilot project at Charter Oak Housing Project to maintain care for rehabilitated patients and provide preventative medical service. If dentures and hearing aids at low cost could be provided, the aged could overcome the embarrassment and insecurity of poor appearance, and the inability to hear well which causes isolation, withdrawal, and sometimes depression because of the inability to socialize adequately in a group.

Committee Members:

Sister Teresa Ann - Saint Francis Hospital - Chairman
(Miss) Anna Fiori - Saint Francis Hospital
(Formerly Director, Meals-On-Wheels)
(Mrs.) Greta Lewis - Saint Francis Hospital
Walter Schafer - Family Service

254.

STATE WIDE PLANNING PROJECT FOR VOCATIONAL REHABILITATION SERVICES

HARTFORD REGIONAL COMMITTEE

Sub-Committee on Mental Health Services

PHILIP W. MORSE, Ph.D.

In preparing this report, the Sub-committee reviewed a number of related reports of other planning committees in the area of mental health, as well as the recommendations of the Joint Commission on Mental Illness and Health authorized by Congress in 1955, and published as Action for Mental Health in 1961 This last was the stimulus for considerable subsequent planning for changes in the area of mental health and treatment on state, regional, and local levels. Three pamphlets related to mental health planning were reviewed; U.S. Dept. of Health, Education & Welfare, Comprehensive Mental Health Planning in Six States 1965; APA Pamphlet, Planning for Mental Health, 1965: State of Connecticut, Mental Health Commission, A Plan for Comprehensive Mental Health Services, 1965; a short brochure produced by the Capitol Region Mental Health Planning Committe (but not its full report which is still not available); and the Joint Commissio Action for Mental Health of 1961.

In only the last of these pamphlets does there seem to be any attention paid to vocational rehabilitation as an essential aspect of the treatment process, and, indeed, as we would look at it, one of the reasonable end products of such treatment. They do propose followup care and posthospital treatment in day care centers, night hospitals, outpatient clinics, and in one case, ther is a brief mention of workshops; but the incorporation of rehabilitation within the treatment process, and its integration into a total treatment plan in any form is not included. They carry treatment only as far as the psychiatric specialty and its related specialties are accustomed to carrying it, and, indeed, offer innovative thinking and planning only in relationship to such treat ment. Following the patient into the community, dealing with him in his social, familial, and vocational setting is not proposed or envisaged. We would feel, however, that complete and completed treatment and a necessary step in reducing recidivism would involve rather intensive work on a community basis and in the community. Indeed, we would feel that such work commences in the hospital or clinic, and continues in the community and after-care activities to assure community and vocational adjustment. The after-care plans proposed in most of the materials read is after-care of a psychiatric nature. It does not include a more broadened attitude that would involve vocational activities as well. In regard to rehabilitation, the joint commission's report says the following:

> After-care, Intermediate Care, and Rehabilitation Services.
>
> The objective of modern treatment to persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possbile, and (3) thereafter maintain him in the community as long as possible. Therefore, after-care rehabilitation is an essential part of all services to mental patients, and the various methods of achieving rehabilitation should be integrated in all forms of services, among them: day hospitals, night hospitals, after-care clinics, public health nursing services, foster family care, convalescent nursing homes, rehabilitation centers, work services, and ex-patient groups. We recommend that demonstration programs for day and night hospitals, and the more flexible use of mental health facilities, both in the treatment of the acute and chronic patient, be encouraged, and augmented through institutional program and project grants."

Even here we see the emphasis on treatment rather than on rehabilitation and readjustment to the community.

We would feel that vocational rehabilitation is a vital part of the treatment process, that the patient, as soon as he is able to think about his post-hospital adjustment, or post day center adjustment, has already started the rehabilitation process, and expert counselors should be readily available to him long before his discharge. The counselor who deals with him in the hospital should be free to continue after his discharge, working with him in the community. The industrial community should be involved with the hospital and even with the patients before discharge, in workshop activities and in recruitment. In this and in other ways, the hospital should be a part of the total community rather than an isolated institution. If the rehabilitation program and process, in this way, becomes totally integrated within the treatment process, the counselor a member of the treatment team, the attitude given the patient is one of hope and expected recovery, and regained competence. Much the same kind of thing could be said about the social work program, that, along with vocational rehabilitation, would bridge the present gap between the community and hospital, a gap which continues to exist in great degree.

In such a program the rehabilitation counselor is a member of the treatment team from the beginning, planning with the team for work assignments in the hospital, in incentive workshop, in training activities within the hospital and in the community, in assessment and evaluation procedures while the patient is still in the hospital. All work-related activities, all contract arrangements, all placement activities are the function of the counselor, who may be an employee of the hospital, or of the Division of Vocational Rehabilitation. He is concerned not only with the patient's work adjustment within the institution, but continues to work with the employer until satisfactory job adjustment has been reached. In sum, we are proposing an attitude toward rehabilitation that would make it an integral part of the treatment process, and would indicate that treatment does not stop with discharge from the hospital, center, or clinic, but only when job adjustment has been achieved; and from the social worker's point of view, when social and familial adjustments have been achieved. The work of the counselor then would be as much in the community as in the hospital or center and would tend, we feel, to move the institution further into integration with the community. We are moving in that direction, but only by setting treatment institutions in towns and cities. We need now to make sure these institutions become really integrated into the community. They can be just as isolated on a city street as they were and are when placed in the country.

STATE WIDE PLANNING PROJECT FOR VOCATIONAL REHABILITATION SERVICES

The general recommendation of this sub-committee, therefore, is that vocational planning, preparation for vocational readjustment and vocational rehabilitation must be made part of the treatment process for the mentally-ill patient. This is true for such patients who are hospitalized, as well as for those in various kinds of outpatient facilities. More specifically:

1. Vocational planning, preparation, placement and final adjustment are part of the total treatment process. Vocational rehabilitation counselors should be part of the treatment team and involved in the treatment process from the very beginning.

2. All hospitals and outpatient services should have counselors either on their professional staffs or assigned by the Division of Vocational Rehabilitation.

3. The counselor is the member of the treatment team who carries treatment into the vocational community. He may work in close cooperation with social workers.

4. That part of the treatment process in which the counselor is the professional expert is "work as therapy", while in the hospital and will include training and placement of the patient outside the hospital.

5. Within the institution there should be industrial workshops and industrial and work assignments. Opportunities for training should be available in industrial, clerical, and technical areas. Such training may well be outside the institution. As the therapist with appropriate training in such areas, the counselor will coordinate and organize such activities.

6. The counselor will work closely with community industry, having the kinds of relationships which will return the patient to a job, hopefully immediately on discharge.

7. The counselor, as a member of the treatment team, should be involved in treatment and discharge planning, and, of course, followup after discharge.

8. Training of vocational counselors may require changes in the curriculum of training institutions to provide more psychiatric and psychotherapeuti orientation in preparation for the kind of job envisaged. There may be a new specialty or a sub-specialty, which may be called psychiatric vocational counselor.

RECOMMENDATIONS MADE BY THE COMMITTEE CONCERNED WITH THE PHYSICALLY AND NEUROLOGICALLY HANDICAPPED

1. There is an urgent need for cooperation between the Division of Vocational Rehabilitation and the Special Education Departments of Connecticut Public Schools. Such programs must include all handicaps, not only mental retardation. (A guide for such a program has been printed by the Division of Vocational Rehabilitation and the Bureau of Pupil Personnel of the Special Educational Services of the State Department of Education, in January 1966.)

2. These programs should be started with provisions for enlarging and extending them.

3. The rehabilitation counselor must function as part of the school staff. He should be present in the early grades as well as at the high school level. It is important, particularly with the physically handicapped, that vocational planning and training be started in the early years. School guidance counselors, social workers, and other special personnel should all work with the rehabilitation counselor.

4. The rehabilitation counselor should be able to cooperate with school personnel in developing a suitable curriculum for the handicapped children.

5. In order to implement these cooperative programs, it is necessary to recruit counselors who will be trained in all aspects necessary to be able to work with the school, the children, their parents, and the community.

There is a need for a comprehensive plan for the rehabilitation of all the handicapped. Starting with the complete diagnostic workup there must be a continuing service of guidance and counseling; vocational evaluation; physical, occupational, and other necessary therapies; vocational training; sheltered workshops; programs of continuing education; recreational and, possibly, residential facilities.

February 26, 1968

MEMO

TO: Mr. Frank G. Grella
Mrs. Sophie Myrun

FROM: James S. Fiske, Assistant Director

RE: Hartford Regional Committee, Statewide Planning Project for Vocational Rehabilitation Services

The following represents a list of needs which the Hartford Rehabilitation Center feels the Hartford Regional Planning Committee should consider:

1. TRANSPORTATION

a) Transportation facilities and schedules within the D.V.R. District make it difficult and/or impossible for some clients to attend a program in Hartford.

b) During the initial stages of rehabilitation, some clients are incapable of using public transportation; they lack experience, judgment or satisfactory physical capacity.

2. PROVISIONS FOR HOUSING

a) There appears to be a need for temporary housing of clients in the Hartford area, for those who live in the surrounding towns and are undergoing an intensive rehabilitation program in a Hartford facility.

b) A survey of available living situations and subsequent co-ordination of their utilization would appear feasible; i.e., Y.M.C.A., Y.W.C.A., Foster Homes, H.I. Jones Home and the proposed State Mental Health Center in Hartford etc.

3. CO-ORDINATION OF TRAINING PROGRAMS

There appears to be a need to coordinate the efforts of present and future training programs -- (C.E.O., Manpower, Community Renewal Team, Voluntary Agencies, Department of Education programs, etc.) in order to insure satisfactory utilization of these programs and resources.

4. PROFESSIONAL TRAINING

a) Rehabilitation personnel appear to lack sophistication in the basic rehabilitation concepts, techniques and methods.

b) There appears to be a lack of sophistication among rehabilitation counselors in terms of disease pathology, transferability of work skills and employment opportunities in business and industry.

5. SHELTERED WORKSHOPS

Sheltered Workshops are seriously misunderstood in terms of capitalization, utilization and program potential. There are several barriers which militate against satisfactory utilization of this type facility: a) wage and hour requirements, b) inadequate subsidy of operating budgets, c) wage subsidies.

6. BUDGETS

The State has not consistently captured Federal Matching Funds. There appears to be a need for short and long range forecasting to insure adequate financial resources. The Hartford Rehabilitation Center has been unable, for several years, to obtain from D.V.R. any type of official projection regarding the types of programs needed and/or number of individuals it anticipates referring for service. Referrals have been erratic.

7. UTILIZATION OF CURRENT FACILITIES

A study of current D.V.R. utilization patterns of providers of services would be most helpful in future planning. (This should include present and projected capacity of the provider.)

8. PUBLIC HEARINGS

The Hartford Regional Planning Committee should conduct public hearings as one tool of determining needs and effectiveness of D.V.R. services. The hearing should include a random sample of providers of service, rehabilitated clients and families, unrehabilitated clients and families, businesses hiring rehabilitated clients and businesses who have not hired clients through D.V.R., etc.

9. SPECIFIC JOB OPENINGS

There appears to be inadequate information available regarding the type, place and number, as well as requisites for specific job openings at any given time. Consideration should be given toward the possibility of centralization and coordination of this data; this would require the cooperation of all interested facilities, businesses and State and Federal Agencies, etc.

REPORT OF SUBCOMMITTEE ON REGIONAL PLANNING ON REHABILITATION OF THE BLIND

WILLIAM W. DUNCAN, CHAIRMAN

Blindness is generally defined as visual acuity for distant vision of 20/200 or less in the better eye with the best correction or more than 20/200 if the widest diameter of the visual field is 20° or less.

There are 3523 blind persons listed on the Board of Education and Services for the Blind registry as of March 1968. However, according to Ralph Hurlin, Ph.D., Chairman of the Committee on Statistics of the Blind, there should be about 4100 blind in the State based upon his estimate of incidences of blind in Connecticut of 1.63 per 1,000. If this figure is correct, then the difference of about 600 would probably represent the elderly who have become blind and perhaps do not wish to be identified as such. There is a State statute which makes it mandatory for opthamologists, optometrists and medical facilities to report to the State agency any person who becomes legally blind. However, we feel that some medical people do not comply fully, particularly with the older person who does not desire services from the agency for the blind or even to be identified as blind.

Of the approximate 3500 known blind in the State:

-1750	or 50% are over age 60
1750	under age 60
- 420	or 12% below age 16
1330	between ages 16 and 60
- 540	employed between ages 16 to 65
790	
- 213	severe multiply-handicapped in institutions
577	not employed
- 300	presently on the rehabilitation case load
277	
- 55	students not yet referred between ages 16 and 19
222	available at present
+ 32	estimated 15% of institutional cases with potential
+ 60	estimated 3½% of age 60 with potential
314	possible rehabilitation cases (this would include many who are not interested in, nor feasible for, rehabilitation

The agency receives about 360 referrals of newly blinded persons of all ages each year. It is estimated that approximately 45% are over 65.

360	average referrals of newly-blinded per year
-160	about 45% over 65
200	
- 25	about 12% below age 16
175	between ages 16 and 65
+ 26	moving into case load from age 16 (420 ÷ 16)
+ 10	readditions or previous rehabilitations
211	potential cases each year

Referrals to the rehabilitation division of the Board of Education and Services for the Blind probably average about 190 per year. Thus it would seem that the majority of blind individuals needing rehabilitation services are receiving such services except perhaps for the older group. Due to the vocational aspects of the present law, it is now difficult to justify providing vocational rehabilitation services to many of these. Many of these need training in adjustment to blindness, mobility, grooming and other daily living activities. There should be legislation to change the Federal Vocational Rehabilitation Law to include rehabilitation services to the geriatric blind individual who has no vocational potential but needs personal adjustment to blindness training desperately.

It is the agency's policy to integrate the blind into general rehabilitation centers and workshops whenever possible, as it is felt that the blind should not be segregated from the sighted world. However, due to the lack of personnel trained in work with the blind in many of these centers, the agency should have its counselors work more closely with them as consultants.

In many cases, general sheltered workshops hesitate to employ the less productive blind client as they usually are less flexible than other handicapped. Another need, therefore, is to have workshops give more employment to this group of blind either on a terminal basis or until they can produce at a level where they can be employed in the competitive labor market.

Another need is a comprehensive residential facility on a regional basis which can provide a variety of needed services to the multipl -handicapped blind which cannot be properly served in a general rehabilitation center. This group often needs highly specialized services as well as a longer evaluation training period than the average newly blinded. Mobility, personal adjustment training, as well as psychotherapy when needed should be included in such a center.

Another need which hopefully will be met in the future, is a national center for the deaf-blind. Under the 1967 amendments to the Vocational Rehabilitation Act, the provision for such a center was established.

Since blindness is a severe disability, it is felt that rehabilitation counselors for the blind should have the benefit of a team to assist in evaluating the potential of a client. Therefore, the agency plans to add an evaluation unit which will involve a team approach in this area.

Mobility has long been an area which has been neglected in work for the blind. The agency now has two mobility instructors and two more have been hired starting this summer. This should do a great deal in alleviating this problem. However, as this is a new field, it may be that more instructors are needed as experience is gained. An adjustment center for blinded veterans, both service-connected and nonservice-connected, will be opened this fall at the Veterans' Administration facility in West Haven. Mobility will be an important area of training in this program.

In providing services to blind children, the agency's rehabilitation staff works closely with both the private and public schools in the State. It is recommended that thought be given to make rehabilitation funds available for initial education for blind children as a requisite to ultimate rehabilitation.

Generally speaking, the funding for the vocational rehabilitation of the blind appears to be adequate for the case load involved. It is felt that this will continue to be true as long as the State can match the Federal funds available. However, if social rehabilitation legislation passes, more funds would be necessary.

Counselor Recruitment and Qualifications (Sub-Committee)

Counselor recruitment has become a problem in Connecticut in the past three years. Up until that time the number of professional counseling staff had remained fairly static for about 10 to 15 years, settling in at about 22 counselors for the entire State. A pay scale existed which at times was the highest in the country for similar State jobs, but which when not the highest, was at least among the first three or four highest. Along with the high pay scale, it offered professional work with professional status. In addition, the State agencies offered one of the few settings where Vocational Rehabilittation Counselor jobs existed. Recruitment of counselors in the past had come primarily from agencies where case-work or job placement had been the principal functions, such as the State Employment Service or the Welfare Departments, or occasionally the school system. Requirements for education training had been limited to a Bachelor's Degree in the behavioral or social service fields and this has been coupled with a working experience requirement of six years. The availability of specific graduate training in Rehabilitation Counseling had been limited to only 2 or 3 colleges in the country. However, about 1956, this State raised its counselor's requirements to a Master's Degree in Vocational Rehabilitation or a related field (psychology, counseling, social work, education, sociology, etc.) plus the 6 years' experience. About the same time colleges began initiating graduate programs in Vocational Rehabilitation. These latter programs were in response to a growing demand for such counselors, both among the State Rehabilitation Agencies and private rehabilitation agencies (such as rehabilitation centers and health agencies).

As the demand for rehabilitation counselors grew, the State agency in particular, and other agencies in general, found recruitment growing difficult. Subsequently, it and they adopted lower experience qualifications in order to fill the openings. Today the agency has four counselor levels, allowing entry as Vocational Counselor Intern with as little qualification as a Bachelor's degree and no work experience. The additional positions, in ascending order, are: Vocational Rehabilitation Assistant Counselor (Master's degree, with no work experience); Vocational Rehabilitation Senior Counselor (Master's degree, plus four years' experience). The salary grades range from Grade 11 upward through Grades 14, 16, and 18, with the following salary range (effective December 29, 1967).

Grade 11 -	$6,710 - $8,210	$250 yearly increment
Grade 14 -	7,940 - 9,920	330 yearly increment
Grade 16 -	8,830 - 10,930	350 yearly increment
Grade 18 -	9,840 - 12,060	370 yearly increment

Although the above salary scales at the upper counselor levels are attractive, the entry level still finds that competition from private agencies (Workshops, Schools, Colleges, Family Agencies, Health Agencies) has diluted Rehabilitation's drawing power. In addition, there is a growing demand for doctorates in the rehabilitation field and related disciplines. This has caused a "pirating" away of competent counselors into teaching, research, and consulting fields.

Added to these problems are the heavy caseloads of most general case counselors (those handling many disabilities). These may range from 135 to 250, or more. It is agreed, in the rehabilitation counseling profession, that a manageable caseload should have 75-100. This State agency, however, has no mandatory maximum case-load figure. Suggestions have been made to try various methods of improving counselor efficiency, such as relieving high caseloads (limiting them to a maximum of 100), of using more clerical aids (recording machines, stenographers, etc.), using rehabilitation aides (non-professionals who can relieve counselors of routine activities), etc. The heavy work load of counselors, today, prevents their reaching for more potential rehabilitants, especially those with mental retardation and orthopedic disabilities.

At the present time (Spring, 1968), there are approximately 58 rehabilitation counselors in this State, (with three openings unfilled.) In order to bring this staff up to sufficient strength to produce 4200 rehabilitants per year by 1971, as directed by the Federal Rehabilitation Service Administration, another 42 counselors will be added by 1971. As to prognostication for counselor needs, it is believed to be safe to say that with the general growth in population over the next 3 years, at least, plus the need to provide greater outreach for cases (counselors in schools, hospitals, etc.) that at least 40 more counselors will be needed by 1971.

As to prognostications to 1975, it is difficult to be specific, but the need for 175 to 180 counselors would not be unreasonable by that time. It is possible that the expansion of our eligibility standards include the disadvantaged, culturally deprived, etc., would call for even a larger counselor staff, so that the goal of 200 counselors by 1975 would be reasonable.

HARTFORD REGIONAL COMMITTEE

Chairman

Mrs. Sophie Myrun
Special Education Teacher
West Hartford

Michael Abdalla, Science Coordinator
Canton High School

Richard Clancy
Hartford Board of Education

William Duncan, Chief
Vocational Rehabilitation Section
Board of Education for the Blind

Norman Fendell, Director
Sheltered Workshop, Manchester

James Fiske, Business Manager
Hartford Rehabilitation Center

Mrs. Marie Francoeur
West Hartford

Clarence Goranson
West Hartford

Mrs. Madelyn Huntington
Cerebral Palsy Association,
Hartford

Mrs. Alice P. Irwin, Treasurer &
Production Manager
Hartford Element Company

Kenneth Jabobs, Pupil Personnel
Department of Education, Hartford

Robert Jemiole, Director
Mansfield Social Adjustment Project
Hartford

John Killian, Pupil Services
West Hartford Board of Education

Harold T. LeMay
Vice President, Industrial
Relations, Chandler Evans, Inc.

Robert Lemke
Industrial & Public Relations
Manager
North & Judd Manufacturing Company

Richard May, Counselor Supervisor
Youth Opportunity Center, Hartford

John McIntosh, D.V.M.
Kensington

Philip M. Morse, Ph.D.
Clinical Psychologist
Veterans Administration Hospital, Newington

Julian Perlstein, Vocational Rehabilitation
Supervisor, Division of Vocational
Rehabilitation

Kenneth L. Poirier
Hartford Regional Center, Newington

Norman Reich, Executive Director
Capitol Region Mental Health Association,
Hartford

* Thomas B. Ritchie
Greater Hartford Community Council

Lawrence Rudd, Instructor of Mentally Retarded
Long Island, New York

Mrs. Edgar T. Sloan, Secretary
Hartford Rehabilitation Center

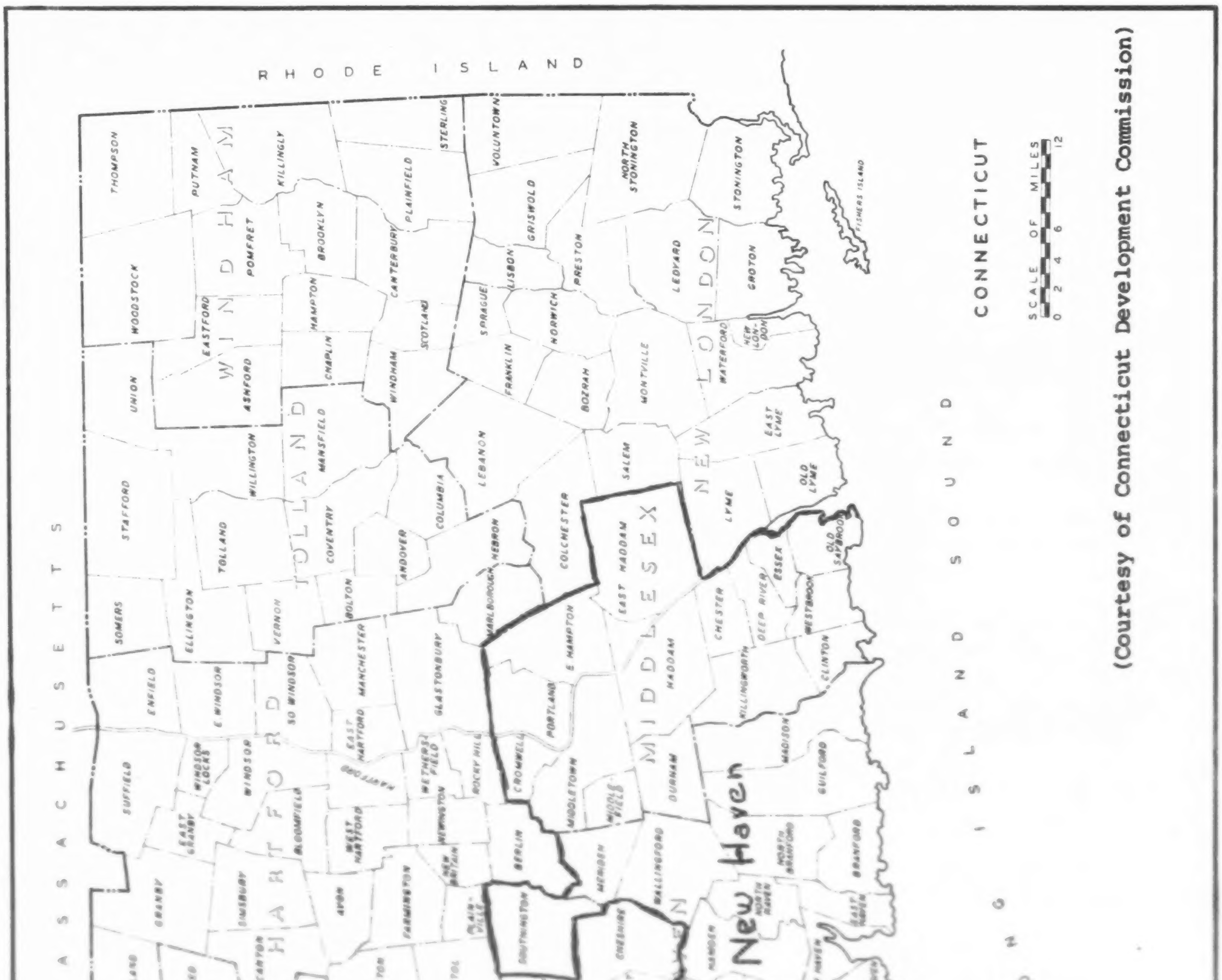
Edward Swift, District Supervisor
Division of Vocational Rehabilitation, Hartford

Mrs. Margaret Tedone
Board of Education, Hartford

Sister Theresa Ann, Associate Director of
Social Services

William Ward, Coordinator of Special Education
Newington Board of Education

* Deceased, September 7, 1968


MASSACHUSETTS
RHODE ISLAND
LONG ISLAND SOUND
NEW YORK
CONNECTICUT
SCALE OF MILES
0 2 4 6 12
WINDHAM
TOLLAND
HARTFORD
LITCHFIELD
MIDDLESEX
NEW LONDON
NEW HAVEN
FAIRFIELD
New Haven
FISHERS ISLAND
THOMPSON
PUTNAM
KILLINGLY
WOODSTOCK
POMFRET
BROOKLYN
PLAINFIELD
STERLING
VOLUNTOWN
NORTH STONINGTON
STONINGTON
GRISWOLD
CANTERBURY
EASTFORD
HAMPTON
LISBON
PRESTON
LEDYARD
GROTON
SPRAGUE
NORWICH
SCOTLAND
CHAPLIN
ASHFORD
UNION
WILLINGTON
MANSFIELD
WINDHAM
FRANKLIN
BOZRAH
MONTVILLE
WATERFORD
NEW LONDON
EAST LYME
SALEM
LEBANON
COLUMBIA
COVENTRY
STAFFORD
TOLLAND
ANDOVER
HEBRON
COLCHESTER
EAST HADDAM
LYME
OLD LYME
OLD SAYBROOK
ESSEX
SOMERS
ELLINGTON
VERNON
BOLTON
MARLBOROUGH
E HAMPTON
HADDAM
CHESTER
DEEP RIVER
WESTBROOK
CLINTON
ENFIELD
E WINDSOR
SO WINDSOR
MANCHESTER
GLASTONBURY
PORTLAND
KILLINGWORTH
MADISON
GUILFORD
SUFFIELD
WINDSOR LOCKS
WINDSOR
EAST HARTFORD
HARTFORD
WETHERSFIELD
ROCKY HILL
CROMWELL
MIDDLETOWN
MIDDLEFIELD
DURHAM
EAST GRANBY
BLOOMFIELD
WEST HARTFORD
NEWINGTON
NEW BRITAIN
BERLIN
MERIDEN
WALLINGFORD
NORTH BRANFORD
BRANFORD
GRANBY
SIMSBURY
AVON
FARMINGTON
PLAINVILLE
SOUTHINGTON
CHESHIRE
HAMDEN
NORTH HAVEN
EAST HAVEN
NEW HAVEN
HARTLAND
BARKHAMSTED
CANTON
BURLINGTON
BRISTOL
WOLCOTT
PROSPECT
BETHANY
WOODBRIDGE
W HAVEN
ORANGE
MILFORD
NEW HARTFORD
NAUGATUCK
SEYMOUR
ANSONIA
DERBY
SHELTON

(Courtesy of Connecticut Development Commission)

¹Map of New Haven Region

I. Rationale for Districting

a) The State Division of Vocational Rehabilitation originally conceived of the New Haven District for administration and provision of rehabilitation services for residents of its thirty-five towns.

b) The area is approximately homogeneous topographically and economically. Most of the residents of this area work within the cities and towns of the New Haven District, although businesses in this area employ significant numbers of commuters from adjacent towns in the other districts.[2]

c) Sub-divisions of this district are frequently taken together as intra-state regions for other planning purposes.

II. Transportation Patterns[3]

Most of the New Haven District is enclosed by the Tri-State Transportation Commission, an agency sponsored by the states of New York, New Jersey, and Connecticut in order to seek solutions to long-range transportation and development problems of the large interstate metropolitan region.

The Supreme Court's recent approval of the merger of the New York Central and Pennsylvania Railroads has guaranteed continued operation of the New York, New Haven, and Hartford Railroad. Although its passenger volume has decreased steadily over the past decades, the New Haven is still deeply involved with the economy of the New Haven District and the State as a whole.

The Wilbur Cross Parkway (Connecticut Route 15), and Interstate Highways 91 and 95 carry the vast bulk of the road traffic in this district, as reflected by the major traffic flow from North to South. The district is also served by a complex network of state and federal highways, the more significant of these being U.S. 1, 5, and 6A, and state routes 9, 19, 17, and 71.

Although the City of New Haven has the best developed public transportation system in the district, public transportation on the whole in the more heavily populated towns (including New Haven, Hamden, Milford, Meriden, and Middletown) is not adequate to the needs of many of the lower socioeconomic level residents.[4]

III. Topography[5]

The New Haven District is confined almost entirely by the geographic regions known as the Central Lowlands and the Coastal Plain. The Central Lowland, which is bisected by the Connecticut River, separates the Rugged Western Uplands from the Rolling Eastern Uplands. This area contains the heaviest concentration of fertile soils in the state, making this section the core of agricultural activity. However, there is high competition between agrarian pursuits and industrial development for the use of this versatile land.

---

[2] Connecticut Department of Labor, Employment Security Division, Dept. of Research and Information, Commuting Patterns in Connecticut, June, 1966.

[3] State of Connecticut, Interregional Planning Program, Transportation, "Connecticut Choices for Action", 1966.

[4] Connecticut Department of Labor, Employment Security Division, Cooperative Area Manpower Planning System Report: Fiscal Year 1968, July 1967, p.277.

[5] State of Connecticut, Connecticut Interregional Planning Program, Conn. Takes Stock for Action, 1964

The District's portion of the Coastal Plain, extending from Milford to the Connecticut River at Old Saybrook, combines seaside activities with the Colonial New England atmosphere. The New Haven harbor, the focal point of this section of the Coastal Plain, is the busiest and most important seaport on the Connecticut Coast. The ever-present danger of pollution, however, threatens the value of surrounding beaches and other water-based recreation facilities.

IV. Economic Data[6]

Approximately 50% more employees in the New Haven District work in non-manufacturing than in manufacturing. The Labor Market Areas of New Haven and Middletown have a larger percentage of non-manufacturing employment than do the other Labor Market Areas.

Close examination of the Labor Market Data provided by the Connecticut State Employment Service indicates a healthy economic and employment opportunity outlook throughout the industrial areas of the District. There are crucial needs for skilled workers, especially in machinery set-up and operation. This all indicates that the better industrial job opportunities will come to the high school graduate with some specialized training in drafting, engineering drawing, and similar technical areas. The demand for unskilled labor will continue to decrease at a fairly rapid rate.

LABOR MARKET INFORMATION

Area	Non-Agricultural Employment			
	Mfg.	Non-mfg.	Gov't.	Total
New Haven District Total	102410	133580	29980	265970

	Unemployment			
	Men	Women	Total	Ratio to Labor Force
	7080	6350	13430	5%

---

[6] Connecticut State Employment Service, Connecticut Labor Department, Data for quarter ending June 30, 1968.

The New Haven District includes two towns of the Bridgeport Labor Market Area. The figures above reflect 14% of the Bridgeport Labor Market information which approximately describes the employment contained within these towns of the New Haven District.

TOTAL NONAGRICULTURAL EMPLOYMENT

Ansonia Area - June 1968

INDUSTRY	June 1968	March 1968	% Change June 1968 over March 1968	June 1967
Total Nonagricultural Employment	13,220	11,880**	+ 11.3	13,210**
Manufacturing	6,880	5,680**	+ 21.1	6,970
Textiles	500	740	+ 6.4	430
Rubber & Misc. Plastic Products	630	610	+ 3.3	640
Primary Metals	2,010	840**	+139.3	2,000
Fabricated Metals and Machinery	2,800	2,810	- 0.4	2,920
*Other Manufacturing	940	950	- 1.1	980
Nonmanufacturing	6,340	6,200	+ 2.3	6,240**
Construction	440	340	+ 29.4	420**
Transportation (Inc. R.R.)	150	130	+ 15.4	200
Communications & Utilities	280	280	0.0	280
Trade	2,410	2,400	+ 0.4	2,350
Wholesale	210	210	0.0	220
Retail	2,200	2,190	+ 0.5	2,130
Finance, Ins. & Real Estate	310	300	+ 3.3	310
Service (Inc. Nonprofit)	1,460	1,440	+ 1.4	1,400
Government	1,290	1,310	- 1.5	1,280

*Other manufacturing includes in the ordnance, food, tobacco, apparel, lumber and wood, paper, printing and publishing, chemicals, stone, clay and glass, electrical equipment, instruments, and miscellaneous manufacturing industries.

**Excludes workers idled due to labor-management disputes.

Unemployment - Ansonia Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	810	5.1%	400	410
May	1968	600	3.8	320	280
April	1968	720	4.6	420	300
March	1968	720	4.6	450	270
June	1967	950	5.8	410	540

TOTAL NONAGRICULTURAL EMPLOYMENT

Meriden Area - June 1968

INDUSTRY	June 1968	March 1968	% Change June 1968 over March 1968	June 1967
Total Nonagricultural Employment	43,570	42,420	+ 2.7	43,660**
Manufacturing	23,380	23,330	+ 0.2	23,870**
Printing and Publishing	710	690	+ 2.9	720
Chemicals	1,180	1,100	+ 7.3	1,210
Primary Metals	2,440	3,320**	+ 5.2	2,110
Fabricated Metals	2,870	2,660**	+ 7.9	2,880
Machinery	3,230	3,270	- 1.2	3,370
Electrical Equipment	1,380	1,370	+ 0.7	1,850
Transportation Equipment	4,360	4,540	- 4.0	4,370
Silverware	4,290	4,270	+ 0.5	4,240
*Other Manufacturing	2,920	3,110	- 6.1	3,120**
Nonmanufacturing	20,190	19,090	+ 5.8	19,790**
Construction	2,070	1,600	+29.4	2,020**
Transportation (Incl. R.R.)	780	770	+ 1.3	830
Communications & Utilities	620	600	+ 3.3	600
Trade	6,870	6,610	+ 3.9	6,890
Wholesale	720	700	+ 2.8	690
Retail	6,150	5,910	+ 4.1	6,200
Finance, Insurance & R.E.	940	890	+ 5.6	910
Service (Incl. Nonprofit)	4,670	4,420	+ 5.6	4,560
Government	4,240	4,200	+ 0.9	3,980

*Other manufacturing includes firms in the food, tobacco, textiles, wood, furniture, paper, rubber, stone, clay and glass, instruments and clocks, and miscellaneous manufacturing industries.

**Excludes workers idled due to labor-management disputes.

Unemployment - Meriden Area

Midmonth	Total	Ratio to Labor Force	Men	Women
June 1968	2,600	5.3%	1,100	1,500
May 1968	2,000	4.0	800	1,200
April 1968	2,100	4.4	900	1,200
March 1968	2,100	4.4	1,000	1,100
December 1967	1,700	3.4	730	970
June 1967	2,100	4.2	1,000	1,100

TOTAL NONAGRICULTURAL EMPLOYMENT

Middletown Area - June 1968

INDUSTRY	June 1968	March 1968	% Change June 1968 Over March 1968	June 1967
Total Nonagricultural Employment	33,950	32,000	+ 6.1	31,960
Manufacturing	14,370	13,980	+ 2.8	13,480
Textiles and Apparel	1,150	1,180	- 2.5	1,190
Paper, Printing & Publg.	1,520	1,580	- 3.8	1,460
Chemicals, Rubber & Plastics	1,850	1,700	+ 8.8	1,620
Fabricated Metals	1,390	1,370	+ 1.5	1,340
Machinery	1,300	1,270	+ 2.4	1,190
Electrical Equipment	1,800	1,780	+ 1.1	1,630
Transportation Equipment	3,310	3,170	+ 4.4	3,030
*Other Manufacturing	2,050	1,930	+ 6.2	2,020
Nonmanufacturing	19,580	18,020	+ 8.7	18,480
Construction	1,420	1,040	+36.5	1,430
Transportation (Inc. R.R.)	310	290	+ 6.9	270
Communications & Utilities	990	940	+ 5.3	840
Trade	5,640	5,200	+ 8.5	5,290
Wholesale	800	780	+ 2.6	780
Retail	4,840	4,420	+ 9.5	4,510
Finance, Ins. & Real Estate	730	700	+ 4.3	730
Service	5,290	4,720	+ 12.1	4,890
Government	5,200	5,130	+ 1.4	5,030

*Other Manufacturing includes firms in the ordnance, food, lumber and wood, furniture and fixtures, leather, stone, clay and glass, primary metals, piano parts, toys and miscellaneous manufacturing industries.

Unemployment - Middletown Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	1,800	4.6%	950	850
May	1968	1,500	3.8	760	740
April	1968	1,500	4.0	870	630
March	1968	1,700	4.4	1,150	550
December	1967	1,400	3.6	870	530
June	1967	1,900	5.0	990	910

TOTAL NONAGRICULTURAL EMPLOYMENT

New Haven Area - June 1968

INDUSTRY	June 1968	May 1968	% Change June 1968 over May 1968	June 1967
Total Nonagricultural Employment	153,930	152,940	+ 0.6	148,640***
Manufacturing	46,750	46,560	+ 0.4	47,320***
Ordnance	5,830	5,640	+ 3.4	5,330
Food	2,040	2,000	+ 2.0	2,180
Apparel & Leather	4,450	4,410	+ 0.9	4,580
Paper	1,590	1,580	+ 0.6	1,560
Printing & Publishing	3,320	3,320	0.0	3,140
Chemicals	1,150	1,150	0.0	1,110**
Rubber & Misc. Plastic Prod.	3,210	3,210	0.0	3,110
Stone, Clay and Glass	1,060	1,050	+ 1.0	640[1]
Primary Metals	3,920	3,920	0.0	4,390
Fabricated Metals	4,790	4,860	- 1.4	4,810**
Machinery	2,360	2,360	0.0	2,490
Electrical Equipment	3,340	3,340	0.0	3,310
Transportation Equipment	6,410	6,530	- 1.8	7,620
*Other Manufacturing	3,280	3,190	+ 2.8	3,050
Nonmanufacturing	107,180	106,380	+ 0.8	101,320***
Construction	8,120	7,970	+ 3.0	7,480[1]
Transportation (Incl. R.R.)	7,370	7,330	+ 0.5	7,380**
Communications & Utilities	6,840	6,720	+ 1.8	6,450
Trade	30,800	30,520	+ 0.9	30,020
Wholesale	8,600	8,510	+ 1.0	8,300
Retail	22,200	22,010	+ 0.9	21,720
Finance, Ins. & Real Estate	7,590	7,500	+ 1.2	7,410
Service	28,810	28,780	+ 0.1	27,180
Government	17,560	17,560	0.0	15,400

*Other manufacturing includes firms in the tobacco, textiles, lumber and wood, furniture and fixtures, paving and roofing materials, instruments, watches and clocks, toys and miscellaneous manufacturing industries.

**Revised.

***Revised and excludes workers idled due to labor-management disputes.

[1] Excludes workers idled due to labor-management disputes.

Unemployment - New Haven Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	7,100	4.0%	4,100	3,000
May	1968	5,500	3.2%	3,800	1,700
April	1968	6,000	3.5%	3,800	2,200
December	1967	5,600	3.3%	3,500	2,100
June	1967	7,100	4.1%	4,400	2,700

LABOR SUPPLY CLASSIFICATION
GROUP "C" MODERATE UNEMPLOYMENT
AS DESIGNATED BY THE U.S. DEPARTMENT OF LABOR

V. EDUCATIONAL AND HEALTH RESOURCES

A. Educational Resources[7]

1. Accedited Institutions of Higher Education

a) Public College

1) Southern Connecticut State College	New Haven
2) Middlesex Community College	Middletown
3) South Central Community College	New Haven

b) Private Junior College

1. Mt. Sacred Heart College	Hamden

c) Other Private Colleges and Universities

1. Albertus Magnus College	New Haven
2. Berkeley Divinity School	New Haven
3. Diocesan Sisters College, Branch	Madison
4. Holy Apostles Seminary	Cromwell
5. New Haven College	New Haven
6. Quinnipiac College	Hamden
7. Wesleyan University	Middletown
8. Yale University	New Haven

2. Private Schools for Special Occupational Training

a) Connecticut School of Electronics	New Haven
b) Culinary Institute of America	New Haven
c) Laurel College	Meriden
d) Paier School of Art	Hamden
e) Stone College	New Haven

3. State Regional Vocational-Technical Schools

a) Eli Whitney Regional Voc.-Tech. School	Hamden
b) Emmett O'Brien Regional Voc.-Tech. School	Ansonia
c) H.C. Wilcox Regional Voc.-Tech. School	Meriden
d) Vinal Regional Voc.-Tech. School	Middletown

4. State-aided Schools for the Disabled

a) Connecticut School for Boys	Meriden
b) Connecticut Valley Hospital School (M.I.)	Middletown
c) Greater New Haven Regional Center (M.R.)	New Haven
d) Walter G. Grady School (Long Lane)	Middletown

---

[7] Connecticut State Department of Education, Educational Directory of Conn., 1967

PUBLIC SCHOOL SERVICES FOR EXCEPTIONAL CHILDREN[8]

NEW HAVEN

TOWN	Learning Disabilities	Mental Retardation	Emotionally Disturbed	Physically Handicapped	Speech & Hearing	Gifted & Talented	Perceptually & Neurologically Impaired	Legally Blind & Partially Sighted	Social Work Services	Psychological Services
1. Ansonia		x			x					
2. Bethany		x			x					
3. Branford	x	x			x					x
4. Chester		x							x	
5. Clinton	x	x			x	x			x	x
6. Cromwell		x	x		x				x	x
7. Deep River		x					x		x	x
8. Derby		x			x				x	x
9. Durham		x								
10. East Haddam	x	x	x		x			x	x	x
11. East Hampton		x			x		x		x	
12. East Haven	x	x			x	x				
13. Essex		x								x
14. Guilford		x			x				x	x
15. Haddam		x							x	x
16. Hamden	x	x			x					x
17. Killingsworth									x	x
18. Madison	x	x	x			x			x	x
19. Meriden	x	x	x		x				x	x
20. Middlefield		x	x				x	x	x	x
21. Middletown		x			x	x			x	
22. Milford		x	x	x	x			x	x	x
23. New Haven		x	x	x	x	x	x	x		x
24. North Branford	x	x			x		x	x	x	x
25. North Haven		x			x	x			x	x
26. Old Saybrook		x			x				x	x
27. Orange	x	x			x					
28. Portland	x	x			x					x
29. Seymour		x	x					x	x	x
30. Shelton		x			x		x			x
31. Southington	x	x			x					x
32. Wallingford		x			x	x				x
33. Westbrook	x	x	x						x	x
34. West Haven		x	x		x				x	x
35. Woodbridge		x					x	x	x	x
										x

---

[8] Connecticut State Department of Education, Bureau of Pupil Personnel and Special Education Services, Directory of Public School Services to Exceptional Children, 1967-1968.

B. Health Resources[9]

1. Locally Administered General Hospitals

a) Bradley Memorial Hospital and Health Center	Southington
b) Gaylord Hospital	Wallingford
c) Griffin Hospital	Derby
d) Hospital of St. Raphael	New Haven
e) Meriden Hospital	Meriden
f) Middlesex Memorial Hospital	Middletown
g) Milford Hospital	Milford
h) Yale-New Haven Hospital	New Haven

2. Publically Administered Hospitals

a) World War II Veterans Memorial Hospital	Meriden
b) Veterans Administration Hospital	West Haven

3. Licensed Private Mental Hospitals

a) Elmcrest Manor	Portland
b) Yale Psychiatric Institute	New Haven

4. Public Mental Hospitals

a) Connecticut Valley Hospital	Middletown
b) High Meadows	Hamden
c) Undercliff Mental Health Center	Meriden

---

[9] State of Connecticut, *Register and Manual*, revised 1966.

VI. Population Data

As indicated in the following tables, the New Haven District is expected to add approximately 120,000 people to its current population by 1975.* This estimated increment, rough as it is, still gives a good indication of the growth to be expected in this District. As the general population increases, the disabled population also increases, and their needs for social and rehabilitation services will rise at a predictable rate.

It may be important to note that most of the population increase will take place in the suburban towns adjacent to the cities of this district, thereby heightening the needs for adequate, dependable inter-town public transportation. Even though the assessment of existing educational and health resources (section V) may not be 100% complete, it is clear that these services will have to be augmented to meet the needs and demands of an additional 120,000 people.

*Method of population projection:

The estimates for 1970 and 1975 indicated on the following table do not take into account such variables as birth and death rates, changes in migration patterns, or fluctuations in employment opportunities. They are based on figures provided by the Connecticut State Department of Health and these data were treated in the following manner:

1) 1960 population subtracted from the 1966 population

2) This six-year population increase (or decrease) was divided by six to obtain the average annual increment (or decrement)

3) The average annual increment was multiplied by four and added to the 1966 population to estimate the 1970 population

4) The average annual increment was multiplied by nine and added to the 1966 population to estimate the 1975 population

This is purely a linear projection.

POPULATION DATA[10]

NEW HAVEN DISTRICT

				STRAIGHT PROJECTION	
COUNTY	TOWNS	1960	1965	1970	1975
Fairfield	Shelton	18190	21400	24840	28160
Hartford	Southington	22797	25000	27470	29800
Middlesex	Chester	2500	2800	3170	3500
	Clinton	4200	6600	9200	11700
	Cromwell	6800	7300	7600	8050
	Deep River	3000	3200	3500	3750
	Durham	3100	3800	4600	5350
	East Haddam	3600	4100	4770	5350
	East Hampton	5400	6400	7900	9150
	Essex	4100	4100	4430	4600
	Haddam	3500	3900	4170	4500
	Killingworth	1100	1600	2100	2600
	Middlefield	3300	4000	4630	5300
	Middletown	33413	34479	35180	36000
	Old Saybrook	5400	8600	10730	13400
	Portland	7500	8200	9000	9750
	Westbrook	2400	3100	3900	4650
New Haven	Ansonia	19819	20500	20790	21260
	Bethany	2400	3100	3730	4400
	Branford	16700	19200	21200	23450
	Derby	12200	12700	13030	13450
	East Haven	21600	25500	28600	32100

---

[10] Hartford National Bank and Trust Company, Market Research Staff, Economic Profiles, 1967.

				STRAIGHT PROJECTION	
COUNTY	TOWN	1960	1965	1970	1975
New Haven	Guiford	8000	9200	11000	12500
	Hamden	41300	47300	55630	62800
	Madison	4600	7000	9600	12100
	Meriden	52270	54198	57000	59380
	Milford	41800	56000	50470	54800
	New Haven	151700	150900	1505500	149900
	North Branford	7000	9600	11830	14250
	North Haven	16200	20300	25030	14250
	Orange	8547	12700	17800	22400
	Seymour	10100	11100	12270	13340
	Wallingford	29920	32800	34200	36370
	West Haven	42400	47200	53250	58680
	Woodbridge	9000	11000	12670	14500

		District Totals			
DISTRICT	TOWNS				
New Haven	35	622,843	688,877	751,890	315,390

VII. Social Agency Offices in the New Haven District.[11]

	Private Agencies	Location
1.	American Cancer Society	Meriden Middletown New Haven
2.	Arthritis Foundation (Yale-New Haven Clinic)	New Haven
3.	Connecticut Association for Mental Health (State Office and Local Office)	Middletown New Haven
4.	Connecticut Association for Retarded Children	East Haven Meriden New Haven North Branford Rockfall
	(Ansonia-Shelton Area)	Shelton
	(Guilford Area)	Southington
5.	Connecticut Heart Association	Meriden Middletown New Haven
6.	Connecticut Society for Crippled Children & Adults (Easter Seal Center)	Meriden New Haven
7.	Connecticut Society for the Prevention of Blindness	Madison
8.	Connecticut TB and Health Association	Middletown
9.	Goodwill Industries (State Office and Local Plant)	New Haven
	(Local Plants)	Meriden Milford
10.	Muscular Dystrophy Association	New Haven
11.	National Foundation for Diseases of the Central Nervous System	Middletown New Haven
12.	National Multiple Sclerosis Society (Clinic and chapter)	New Haven

---

[11] R.W. Bain, (ed.), Directory of Rehabilitation Resources in Conn., 1966;

Public Agencies	Location
1. Office of Economic Opportunity Agencies	
a) Community Action Agency	Meriden
b) Community Progress, Inc.	New Haven
c) Greater Middletown Community Action	East Hampton Middletown Portland
d) Opportunities Industrialization, Inc.*	New Haven
2. State Department of Education (District Office)	New Haven
Division of Vocational Rehabilitation (Local Office)	Meriden
3. State Department of Health (Monthly Clinic at Griffin Hospital Crippled Children Section	Derby
4. State Department of Health Office of Mental Retardation	New Haven
5. State Department of Health Office of TB Control (Out-Patient Services)	Meriden Middletown Shelton
6. State Department of Labor Connecticut Employment Service (Local Offices)	Ansonia Meriden Middletown Milford New Haven
7. State Department of Mental Health (Alcoholism Clinic)	New Haven
8. Veterans Administration Office	New Haven

---

*Not federally sponsored but working with and drawing from the inner city populace.

POSSIBLE RECOMMENDATION FOR CONSIDERATION OF THE NEW HAVEN REGIONAL PLANNING COMMITTEE ON VOCATIONAL REHABILITATION

1. The Division of Vocational Rehabilitation should continue to provide funds for purchase of rehabilitation services, including detoxification for addicts to both alcohol and drugs. Addiction to both alcohol and drugs is on the increase in this area. At the same time, vocational rehabilitation services for the special needs of these addicts are in a rudimentary stage. A recent report of the Community Council of Greater New Haven identified the network of services needed for rehabilitation of the alcoholic. The Council and other community groups are attempting to develop the needed services. As these services become available, the Division of Vocational Rehabilitation will experience an increase in the number of alcoholics seeking rehabilitation services.

2. The definition of "rehabilitation services" should be broadened to include services for those who are handicapped due to cultural or social deprivation. Funds should be made available to the Division to serve this population.

3. The Division of Vocational Rehabilitation should take the responsibility for public education, coordination, and the fostering of communication between the agencies whose services it purchases.

4. Due to the extensive need for vocational rehabilitation services to conserve and develop human abilities and talents, and due to the public benefit that results from the employment of those who without appropriate services and training could not be employed, the Committee strongly recommends that the Division of Vocational Rehabilitation receive from the State sufficient funds to match all available Federal funds. Since the

State operates on the basis of a two year budget and the Federal budget is changed each year, State funds should be allocated at a level that will match available Federal funds the first year, with allowance made for a substantial increase in the second year.

5. The Division of Vocational Rehabilitation should experiment in providing grants to sheltered workshops and other vocational rehabilitation services from funds presently used on a client-to-client purchase of service basis.

6. The Division should extend its vocational rehabilitation services to the State jail serving the New Haven area.

7. The Committee notes and deplores the confusion and the lack of coordination among various State departments and divisions serving similar populations; for example, the Alcoholism & Drug Dependency Division, Department of Corrections, Division of Vocational Rehabilitation, Welfare Department, and the Office of Mental Retardation.

EXCERPTS FROM REPORT OF MICHAEL E. TARANTINO, EXECUTIVE DIRECTOR, TUBERCULOSIS AND HEALTH ASSOCIATION OF THE NEW HAVEN AREA, INC.

As I mentioned to you, I think that, in the future, plans should be made to provide a completely comprehensive Center for patients with respiratory diseases. I don't necessarily mean that this has to be a separate facility; it can be conducted within the auspices of a well-run, well-organized rehabilitation center.

I feel that there should be some liaison between the hospital and the Center and that trained personnel, which would include physiotherapists, inhalation therapists and a physician knowledgeable in chest diseases, should be a necessary part of the staff. This would further include counselors, etc.

It would be quite necessary that this Center contain the facilities for intermittent positive pressure reading, personnel to conduct breathing exercise programs, as well as vocational training and placement facilities. However, I realize that this is utopian in many ways.

The patients who would be handled would be not only those having emphysema and chronic bronchitis, but asthmatics, the tubercular, and some people with only acute shortness of breath.

I would like, further, to emphasize some of the recommendations made in the enclosed reports:

1 - Special emphasis should be placed on the provision of rehabilitation services to all prospective clients with pulmonary and respiratory diseases.

2 - Rehabilitation counselors should be provided with specialized training in tuberculosis and other pulmonary and respiratory diseases, in order that they may better understand the patient's special problems and needs.

3 - Training opportunities at rehabilitation workshops (sheltered workshops) can be diversified to include training opportunities for persons with pulmonary and respiratory disabilities.

4 - Development of a standard and simplified form for reporting a patient's work tolerance will be of great value to all persons interested in the eventual rehabilitation of respiratory disease patients.

REPORT OF JACK SAGE, COMMUNITY COUNCIL OF GREATER NEW HAVEN, INC.

Vocational Rehabilitation

Following meetings with representatives of the Department of Vocational Rehabilitation, Community Progress, Inc., Goodwill Industries, and the New Haven Area Rehabilitation Center, it was recommended that:

An intensive series of meetings should be convened by the Community Council with the executives and Board Presidents of the above agencies to accomplish the following five objectives:

1. To outline the function of Goodwill Industries and the Rehabilitation Center in regard to the handicaps each agency services, as well as the kinds of rehabilitation each performs.
2. To explore the feasibility of Goodwill Industries subcontracting with the Rehabilitation Center for the professional supervision required in its sheltered workshop.
3. To determine the extent of subcontracting with industry that can be accomplished cooperatively between Goodwill Industries and the Rehabilitation Center in order to avoid duplication and competition.
4. To develop funding proposals with Community Progress, Inc. that will utilize the training and vocational rehabilitation programs of Goodwill Industries and the Rehabilitation Center.
5. To explore the utilization of the services of Goodwill Industries and the Rehabilitation Center by the Department of Vocation Rehabilitation.

The five objectives above were adopted on the basis of the following conclusions of the Committee:

1. Although Goodwill Industries and the Rehabilitation Center have explored the possibilities of an organic merge (and to date this has not been resolved), the Committee recommends that agreements be reached in regard to numbers 1, 2, and 3 above.
2. Goodwill Industries has the potential to develop an excellent training program in service trades, such as garment repair, laundry and dry cleaning, textile refinishing, appliance repair, etc., provided that secondary funding support can be developed.
3. The New Haven Area Rehabilitation Center already has an excellent comprehensive rehabilitation program. Goodwill Industries should not duplicate services, such as diagnostic testing and evaluation, already offered by the Rehabilitation Center. Professional services should, perferably, be provided to Goodwill Industries through contact with the Rehabilitation Center.
4. Since the Rehabilitation Center already has extensive subcontracts with industry, and since Goodwill Industries is interested in developing similar subcontracts, a combined and coordinated approach to subcontracting with industry is recommended.

SCHEMATIC PRESENTATION OF RECOMMENDED NETWORK OF SERVICES FOR THE ALCOHOLIC

STAGES	PROGRAM
Contact or Pre-Treatment Stage	1. The Union of Indigent People operating in four neighborhoods and providing lodging and group programming.
	2. A program designed to stimulate efforts of police, clergy, employers, and community agencies.
	3. A rehabilitation officer within the Police Department relating police, jails, and courts to community resources.
Detoxification	4. A detoxification center located in New Haven to allow quick, easy access to police and community agencies.
Extended Treatment	5. Psychological and social adjustment on an out-patient basis: a. The primary responsibility of an expanded Alcoholism and Drug Dependecy Clinic. b. A secondary responsibility of the Connecticut Mental Health Center
	6. A residential program stressing vocational rehabilitation and independent employment.
	7. A residential program providing sheltered employment.
Other Approaches	8. A restructured legal procedure in accordance with recent recommendations of the New Haven Legal Assistance Association.
	9. A continued active Alcoholics Anonymous program.
	10. Planning and implementation of the above recommendations through efforts of the Community Council and other community agencies.

REGIONAL PLANNING COMMITTEE FOR VOCATIONAL REHABILITATION

SUB-COMMITTEE TO ESTABLISH EXISTING SOURCES AND NEEDS FOR THE HANDICAPPED

1. *Regional Information Bureau used as a clearing house for clients who need services.

   a. Referred to: Guide to Social Resources
   Directory of Community Resources for Health, Welfare, and Recreation. Eliminate duplication of further programs in agencies. Establish more beneficial programs and have these registered with the Information Bureau (mandatory).

   *Bureau will send out bulletins to all registered agencies to supply up-to-date data on new and existing programs.

   b. Basic rules:

      1. Unit of Capability - spirit or will to work must be indicated.
      2. Computorization - less staff
         more speed and accuracy

   c. Detailed form to Bureau for suggested placement:

      1. List by number, not by name and address

QUESTIONS

1. Where will funds come from?
2. What type of administrative agency for Bureau?
3. Where will Bureau be established?

NEEDS

Services for:

Unwed Mothers
Narcotics Addicts
Multiply-handicapped: crippled, financially deprived, mentally retarded

More Consulting Services: medical, psychiatric, psychological
Head-start Program for siblings of the retarded (preventive rehabilitation)
Group homes for the retarded (houses in communities)
Closed or sheltered workshops (encompassing every type of handicap and condition)
Vocational Counselors: in every area of rehabilitation
Job and Agency Placement: utilize the Bureau.

Committee Members: Mrs. Helen Fish, Chairman; Messrs. Richard K. Conant, Carl Puleo, Herman Scott, and Michael Tarantino

NEW HAVEN REGIONAL COMMITTEE

Chairman

Albert Calli
Director
New Haven Rehabilitation Center

Robert Becker, M.D., Director
of Rehabilitation Connecticut
Mental Health Center, New Haven

Randall Blanchard
New Haven Regional Center

Miss Edith Carnes
Hamden

Joseph Colombatto, Director
New Haven Regional Center

Richard K. Conant, Jr., Project
Director, Health Education
Demonstration Project Griffith
Hospital, Derby

Peter Corato, District Supervisor
Division of Vocational
Rehabilitation

Mrs. Nicholas D'Esopo, Superintendent
Clinical Social Worker
Social Service Department
Westerams Administration Hospital
New Haven

George Dorian, M.D., Director
of Physical Medicine &
Rehabilitation Hospital of
St. Raphael, New Haven

Mrs. Helen Fish
New Haven Regional Center of
Retarded

Walter Glinski, Executive Director
Regional Training Center & Sheltered
Workshop, Meriden

Francis P. Guida, M.D.
New Haven

Frank Harris, Executive Director
Community Council of Greater New Haven

Miss Louise Kingston, Council Interviewer
Connecticut State Employment Service

Miss Blanche Miller
Community Progress Inc., New Haven

Alfred O'Dell, Personnel Manager
Hersey Metal Products Inc., Ansonia

Carl Puleo, Executive Director
Goodwill Industries of Central Connecticut,
New Haven

Henry Rohde
Division of Vocational Rehabilitation

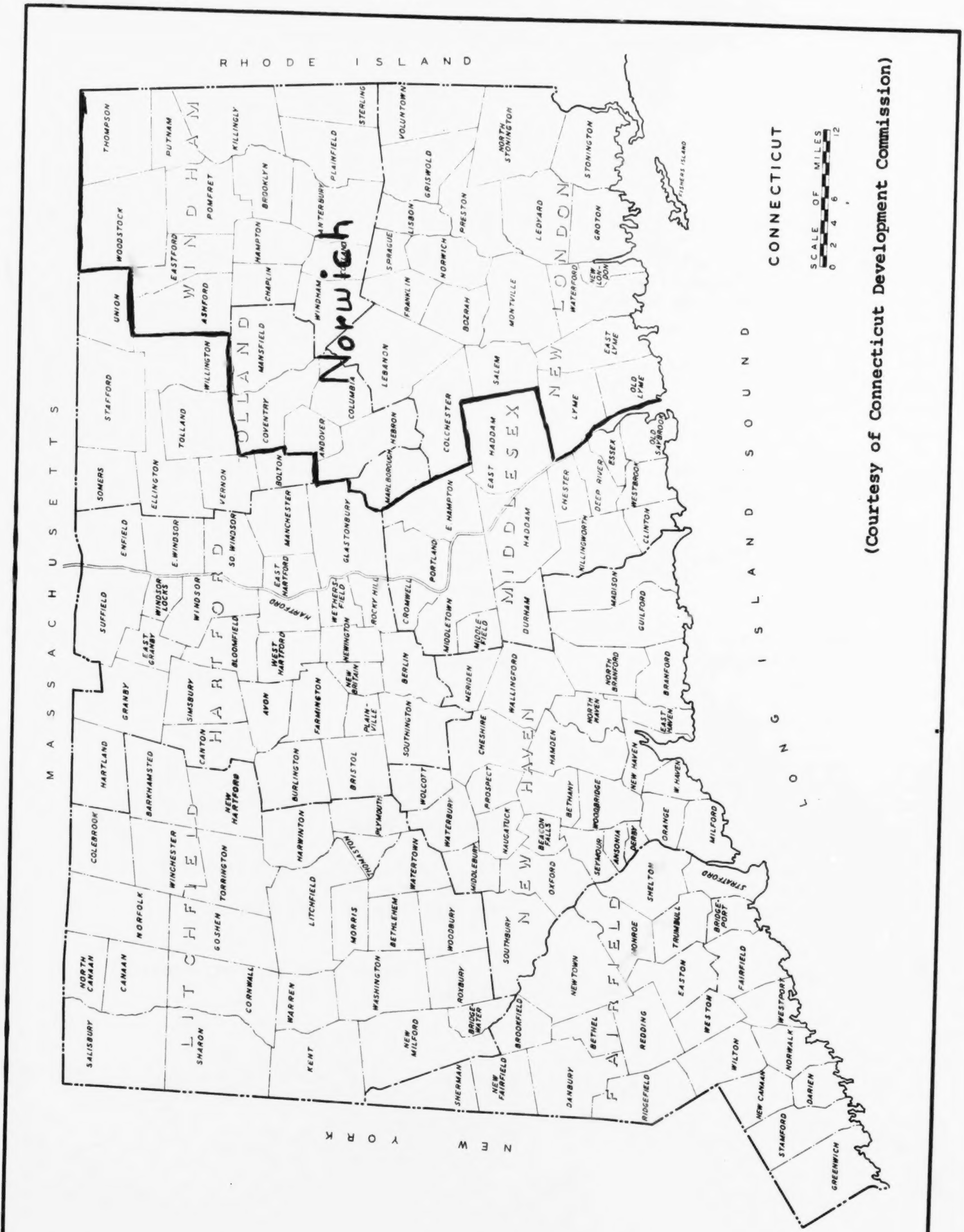
Murrary Rothman, Director
Pu;ip Service, Beecher School, New Haven

Jack Sage
Community Council of New Haven

Michael Tarantino, Executive Director
Tuberculosis & Health Association of
New Haven Area

Miss Joyce Willard, Rehabilitation
Coordinator
Gaylord Hospital, Wallingford

George Zitnay
Central Connecticut Regional Center,
Meriden


CONNECTICUT
SCALE OF MILES
0 2 4 6 12
RHODE ISLAND
MASSACHUSETTS
NEW YORK
LONG ISLAND SOUND
WINDHAM
TOLLAND
NEW LONDON
MIDDLESEX
HARTFORD
LITCHFIELD
NEW HAVEN
FAIRFIELD
Norwich

(Courtesy of Connecticut Development Commission)

[1] Map of Norwich Region

PROFILE OF NORWICH REGION

I. Rationale for Districting

a) The State Division of Vocational Rehabilitation originally conceived of the Norwich District for administration and provision of rehabilitation services for rehabilitation services for residents of the forty-two towns.

b) The area is topographically and economically homogeneous. Most of the residents of this area work within the cities and towns of the Norwich District.

II. Transportation Patterns[2]

Traffic in the Norwich District travels mostly east-west, as reflected by the location of the major highways: Interstate 84, running northeast-southwest adjacent to the northern part of the district. U.S. 1 and 195 in the southern end of the district, and U.S. 6, 6A, 44, and 44A in the central area. Major north-south traffic is carried by state routes 2, 12, 32, 52, and 85.

A large majority of the residents of the District use automobile transportation to get to work. Additionally, more residents walk than ride buses. Although the Connecticut Interregional Planning Program has not published information about bus transportation particular to the Norwich District, it is generally understood that the population patterns at present cannot support a sophisticated rapid transit system established District-wide.

III. Topography[3]

Except for the coastal towns, the Norwich District falls within the geographical region termed the Eastern Uplands. From an elevation of 1000 feet near the Massachusetts border, these rolling hills slope southward to the Long Island Sound. In general, the area is densely wooded, containing hundreds of small ponds and lakes, remnants of the Ice Age. Most of the urban development is situated on the Thames, Quinebaug, and Shetucket Rivers.

The coastal towns fall within the Coastal Plain, which extends from Greenwich to Pawcatuck. Roughly 75 of the 253 miles of irregular shoreline of the Coastal Plain lie within the Norwich District. This area is nationally known for sport as well as commercial fishing and lobstering and is dotted with public and private salt-water beaches.

IV. Economic data (Labor Market Letters)

Roughly 16% of the employees in the Norwich District are employed by some government agency. This is due in large degrees to the many government installations being located within this district, such as the University of Connecticut, Norwich State Hospital, and the Submarine Base in Groton. Government employment is expected to increase, as state agencies such as the Office of Mental Retardation and the Department of Education continue to expand. A significant portion of the labor market is employed in national defense-oriented industry, and due to this the economy of the district is heavily dependent upon the nation's defense budget.

LABOR MARKET INFORMATION[4]

Area		Non-Agricultural Employment		
	Mfg.	Non-mfg.	Govt.	Total
Norwich District Totals	45270	39400	20930	105600

		Unemployment	
Men	Women	Total	Ratio to Labor Force
3130	3480	6610	6.2%

---

[2] Connecticut Interregional Planning Program, Transportation, State of Conn.

[3] Connecticut Interregional Planning Program, Conn. Takes Stock for Action, State of Conn., 1964, pp. 45-46.

[4] Connecticut State Employment Service Data for quarter ending June 1968.

TOTAL NONAGRICLUTURAL EMPLOYMENT

Danielson Area - June 1968

INDUSTRY	June 1968	March 1968	% Change June 1968 over March 1968	June 1967
Total Nonagricultural Employment	18,360	17,010**	+ 7.9	17,620**
Manufacturing	11,290	10,440**	+ 8.1	10,990
Food	430	490	- 12.2	430
Textiles	3,330	3,170	+ 5.0	3,170
Apparal and Leather	800	840	- 4.8	860
Lumber, Furniture & Paper	1,470	1,510	- 2.7	1,720
Rubber and Misc. Plastic Prod.	1,180	1,090	+ 8.3	1,100
Stone, Clay and Glass	1,120	440**	+154.5	980
Fabricated Metals & Aircraft	1,150	1,110	+ 3.6	1,060
*Other Manufacturing	1,810	1,790	+ 1.1	1,670
Nonmanufacturing	7,070	6,570	+ 7.6	6,630**
Construction	500	350	+ 42.9	420**
Trans., Comm., & Utilities	500	470	+ 6.4	490
Trade	2,210	1,980	+ 7.1	2,040
Wholesale	220	210	+ 4.8	210
Retail	1,900	1,770	+ 7.3	1,830
Finance, Ins., & R.E.	310	310	0.0	310
Service	2,160	1,980	+ 9.1	1,930
Government	1,480	1,480	0.0	1,440

*Other manufacturing includes firms in the printing and publishing, chemicals, paving and roofing materials, primary metals, machinery, electrical equipment, instruments, and miscellaneous manufacturing industries.
**Excludes workers idled by labor-management disputes.

Unemployment - Danielson Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	1,100	4.9%	440	660
May	1968	940	4.3	410	530
April	1968	1,100	5.4	530	570
March	1968	1,400	6.6	880	520
December	1967	1,100	5.3	510	590
June	1967	1,200	5.4	560	640

TOTAL NONAGRICULTURAL EMPLOYMENT

New London Area - June 1968

INDUSTRY	June 1968	May 1968	% Change June 1968 over May 1968	June 1967
Total Nonagricultural Employment	50,500	49,660	+ 1.7	48,440**
Manufacturing	23,480	23,470	0.0***	22,440**
*Metallic	17,780	17,860	- 0.4	17,020
**Nonmetallic	5,700	5,610	+ 1.6	5,420**
Nonmanufacturing	27,020	26,190	+ 3.2	26,000**
Construction	1,580	1,540	+ 2.6	1,370**
Transportation (Inc. R.R.)	1,350	1,310	+ 3.1	1,430
Communications & Utilities	920	900	+ 2.2	910
Trade	8,440	8,170	+ 3.3	8,060
Wholesale	1,090	1,070	+ 1.9	1,060
Retail	7,350	7,100	+ 3.5	7,000
Finance, Ins. & Real Estate	890	870	+ 2.3	880
Service	5,980	5,720	+ 4.5	5,770
Government	7,860	7,680	+ 2.3	7,580

*Metallic includes firms in the primary metals, fabricated metals, machinery, electrical equipment, transportation equipment, instruments and miscellaneous metallic manufacturing industries.

**Nonmetallic includes firms in the food, textiles, apparel, lumber and wood, furniture and fixtures, paper, printing and publishing, chemicals, petroleum and coal products, rubber and plastics, stone, clay and glass, and miscellaneous nonmetallic manufacturing industries.

***Less than 0.05 percent.

Unemployment - New London Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	2,800	4.9%	1,400	1,400
May	1968	1,900	3.5	1,030	870
April	1968	1,900	3.5	1,170	730
December	1967	1,700	3.0	930	770
June	1967	2,700	4.7	1,890	810

EARNINGS AND HOURS* - JUNE 1968 - MARCH 1968 - JUNE 1967

- Manufacturing Production Workers Only -

New London Labor Market Area

INDUSTRY	AVERAGE WEEKLY WAGES			AVERAGE WEEKLY HOURS			AV. HRLY. EARNINGS		
	June 1968	March 1968	June 1967	June 1968	March 1968	June 1967	June 1968	March 1968	June 1967
Total Manufacturing	$136.36	$134.27	$121.79	41.7	41.7	39.8	$3.27	$3.22	$3.06
Metallic	137.12	136.78	121.76	41.3	41.7	38.9	3.32	3.28	3.13
Nonmetallic	134.39	128.44	122.47	42.8	41.7	41.8	3.14	3.08	2.93

*Weekly wages and hourly earnings shown here are averages only and do not necessarily indicate earnings at individual firms. There is a wide range of averages within certai groups and these figures should not be used as an indication of wages and hours for individuals.

TOTAL NONAGRILCUTURAL EMPLOYMENT

Norwich Area - June 1968

INDUSTRY	June 1968	March 1968	% Change June 1968 over March 1968	June 1967
Total Nonagricultural Employment	20,490	19,880	+ 3.1	19,760*
Manufacturing	6,120	6,240	- 1.9	6,430
Textiles	790	750	+ 5.3	860
Apparel	630	670	- 6.0	660
Paper	1,070	1,040	+ 2.9	1,090
Leather	280	280	0.0	420
Fabricated Metals	1,160	1,100	+ 5.5	1,100
**Other Manufacturing	2,190	2,400	- 8.7	2,290
Nonmanufacturing	14,370	13,640	+ 5.4	13,330*
Construction	950	720	+31.9	820*
Transportation (Inc. R.R.)	660	620	+ 6.5	650
Communications & Utilities	290	280	+ 3.6	270
Trade	4,560	4,440	+ 2.7	4,220
Wholesale	740	680	+ 8.8	710
Retail	3,820	3,760	+ 1.6	3,510
Finance, Ins. & Real Estate	510	500	+ 2.0	500
Service (Inc. Nonprofit)	2,920	2,670	+ 9.4	2,660
Government	4,480	4,410	+ 1.6	4,210

*Excludes workers involved in a labor-management dispute.

**Other manufacturing includes firms in the food, lumber and wood, printing and publishing, chemicals, stone, clay and glass, primary metals, machinery instruments and miscellaneous manufacturing industries.

Unemployment - Norwich Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	1,600	6.4%	700	900
May	1968	1,400	5.7	600	800
April	1968	1,700	6.9	900	800
March	1968	1,600	6.9	880	720
December	1967	1,500	6.0	730	770
June	1967	1,700	6.9	980	720

TOTAL NONAGRICULTURAL EMPLOYMENT
Willimantic Area - June 1968

INDUSTRY	June 1968	March 1968	% Change June 1968 over March 1968	June 1967
Total Nonagricultural Employment	16,250	16,510	- 1.6	16,370
Manufacturing	4,380	4,440	- 1.4	4,870
*Metallic	2,260	2,240	+ 0.9	2,360
**Nonmetallic	2,120	2,200	- 3.6	2,510
Textiles	1,610	1,680	- 4.2	1,970
Nonmanufacturing	11,870	12,070	- 1.7	11,500
Construction	370	250	+48.0	300
Trans., Comm., & Utilities	480	470	+ 2.1	470
Trade	2,200	2,170	+ 1.4	2,160
Wholesale	160	160	0.0	150
Retail	2,040	2,010	+ 1.5	2,010
Finance, Ins. & Real Estate	220	210	+ 4.8	220
Service (Inc. Nonprofit)	1,490	1,380	+ 8.0	1,360
Government	7,110	7,590	- 6.3	6,990

*Metallic includes firms in the fabricated metals, machinery, electrical products, instruments, and miscellaneous manufacturing industries.
**Nonmetallic includes firms in the food, textiles, wood, printing & publishing, chemicals, and rubber industries.

EARNINGS AND HOURS* - JUNE 1968, MARCH 1968 AND JUNE 1967
- Manufacturing Production Workers Only -
Willimantic Labor Market Area

INDUSTRY	AV. WKLY. WAGES			AV. WKLY. HRS.			AV. HRLY. EARNINGS		
	June 1968	March 1968	June 1967	June 1968	March 1968	June 1967	June 1968	March 1968	June 1967
Total Manufacturing	$88.82	$89.72	$84.32	39.3	39.7	38.5	$2.26	$2.26	$2.19

*Weekly wages, hours, and hourly earnings, shown in this bulletin are averages only and do not necessarily indicate earnings of individual firms. There is a wide range of averages within certain groups and these figures should not be used as an indication of wages or hours for individual plants.

Unemployment - Willimantic Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	1,110	5.1%	590	520
May	1968	800	3.8	380	420
April	1968	770	3.7	490	280
March	1968	950	4.6	620	330
December	1967	810	3.9	440	370
June	1967	1,510	6.9	460	1,050

V. EDUCATIONAL AND HEALTH RESOURCES

A. Educational Resources[5]

1. Accredited Institutions of Higher Education

    a) Public Junior Colleges

        1. Thames Valley St. Technical Institute........Norwich
        2. University of Connecticut Branch.............New London

    b) Other Public Colleges and Universities

        1. University of Connecticut....................Storrs
        2. Eastern Conn. State College..................Willimantic
        3. U.S. Coast Guard Academy.....................New London

    c) Private Junior College

        1. Mitchell College.............................New London

    d) Other Private Colleges

        1. Annhurst College.............................S. Woodstock
        2. Connecticut College..........................New London
        3. Diocesan Sisters College Branch..............Putnam

2. Private Schools for Special Occupational Training

    a) New London Business College.....................New London
    b) Norwich Commercial College.......................Norwich

3. State Regional Vocational-Technical Schools

    a) Harvard Ellis Regional Voc.-Tech.................Danielson
    b) Norwich Regional Voc.-Tech.......................Norwich
    c) Windham Regional Voc.-Tech.......................Windham

4. State Aided Schools for the Disabled

    a) Mystic Oral School (deaf)........................Mystic
    b) Mansfield State Training School (MR).............Mansfield
    c) Northeast Regional Center (MR)...................Putnam
    d) Seaside Regional Center (MR).....................Waterford

---

[5] Conn. State Department of Education, Educational Directory of Conn., Hartford, Connecticut, 1967.

PUBLIC SCHOOL SERVICES FOR EXCEPTIONAL CHILDREN[6]

NORWICH REGION

TOWN	Learning Disabilities	Mental Retardation	Emotionally Disturbed	Physically Handicapped	Speech & Hearing	Gifted & Talented	Perceptually & Neurologically Impaired	Legally Blind & Partially Sighted	Social Work Services	Psychological Services
1. Andover		x							x	
2. Ashfords		x							x	
3. Bozrah		x							x	
4. Brooklyn		x				x		x		x
5. Canterbury		x								x
6. Chaplin		x							x	
7. Colchester		x	x				x		x	x
8. Columbia		x							x	
9. Coventry	x	x							x	x
10. Eastford		x							x	
11. East Lyme		x	x			x	x			x
12. Franklyn		x							x	
13. Griswold		x						x		x
14. Groton		x			x		x	x	x	x
15. Hebron		x							x	
16. Hampton		x							x	
17. Killingly		x								x
18. Lebanon		x							x	
19. Ledyard		x			x		x	x		
20. Lisbon		x								
21. Lyme									x	
22. Marlborough		x							x	
23. Mansfield		x	x		x		x		x	
24. Montville	x	x	x				x			
25. New London		x	x		x			x		x
26. North Stonington		x								
27. Norwich		x				x	x			x
28. Old Lyme		x			x					
29. Plainfield		x						x		x
30. Pomfret		x								x
31. Preston		x								
32. Putnam		x						x		x
33. Salem		x							x	
34. Scotland		x							x	
35. Sprague		x								
36. Sterling		x								x
37. Stonington	x	x			x			x		
38. Thompson		x								x
39. Voluntown		x								
40. Waterford	x	x	x		x		x	x		x
41. Windham	x	x			x	x			x	x
42. Woodstock		x								x

---

[6] Connecticut State Department of Education, Bureau of Pupil Personnel and Special Education Services, Directory of Public School Services to Exceptional Children, 1967-1968.

B. Health Resources[7]

1. Locally Administered General Hospitals

a) Lawrence and Memorial Hospitals	New London
b) William Backus Hospital	Norwich
c) Day-Kimball Hospital	Putnam
d) Windham Community Memorial Hospital	Windham

2. Licensed Private Mental Hospital

a) Natchaug	Willimantic

3. Public Mental Hospital

a) Norwich State Hospital	Norwich

4. Public Tuberculosis Hospital

a) Uncas-On-Thames	Norwich

VI. POPULATION DATA

As indicated in the following table, the Norwich District is expected to add approximately 119,000 people to its current population by 1975*. This estimated increment, rough as it is, still gives a good indication of the growth to be expected in relatively rural Eastern Connecticut. As the general population increases, the disabled population increases, and their needs for social and rehabilitation services will rise at a predictable rate. Even though the assessment of existing social services may not be 100% complete, it is clear that these services will have to be augmented to meet the needs of an additional 119,000 people.

*Method of population projection:

The estimates (for 1970 and 1975) indicated on the following table do not take into account such variables as birth and death rates, changes in migration patterns, or fluctuations in employment opportunities. They are based on figures provided by the Connecticut State Department of Health and these data were treated in the following manner:

1. 1960 population subtracted from the 1966 population.
2. This six-year population increase (or decrease) was divided by six to obtain the average annual increment (or decrement).
3. The average annual increment was multiplied by four and added to the 1966 population to estimate the 1970 population, and the average annual increment was multiplied by nine and added to the 1966 population to estimate the 1975 population.

*This is purely a linear projection.

---

[7] State of Connecticut; Register and Manual, Secretary of the State, Hartford, Connecticut, revised 1966.

POPULATION DATA

NORWICH DISTRICT[8]

COUNTY	TOWNS	1960	1965	STRAIGHT PROJECTION	
				1970	1975
Hartford	Marlborough	1961	2200	2360	2560
Tolland	Andover	1800	2000	2300	2550
	Columbia	2200	2600	3040	3340
	Coventry	6356	7600	9100	10470
	Hebron	1800	2300	2640	2940
	Mansfield	13000	18633	23050	28040
New London	Bozrah	1600	2000	2270	2560
	Colchester	4648	5500	5900	6530
	East Lyme	6836	8849	10840	12840
	Franklin	974	1100	1200	1300
	Griswold	6472	7000	7690	88300
	Groton	30100	35400	38700	43350
	Lebanon	2500	3200	3870	4450
	Ledyard	5500	9200	13000	16750
	Lisbon	2019	2400	2650	2970
	Lyme	1200	1400	1530	1700
	Montville	7900	12200	16400	20650
	New London	34100	33300	33340	33850
	N. Stonington	2000	2800	4000	5000
	Norwich	38644	40800	43220	45510
	Old Lyme	3100	3600	3930	4350
	Preston	4967	5209	5240	5375

				STRAIGHT PROJECTION	
COUNTY	TOWN	1960	1965	1970	1975
New London	Salem	930	1200	1545	1855
	Sprague	2509	2600	2830	2990
	Stonington	14000	15000	16170	17250
	Voluntown	1000	1200	1500	1750
	Waterford	15387	16800	18960	20740
Windham	Ashford	1315	1600	1790	2030
	Brooklyn	3312	4700	5125	5530
	Canterbury	1857	2300	2930	3460
	Chaplin	1230	1500	1680	1900
	Eastford	746	880	985	1100
	Hampton	934	990	1040	1090
	Killingly	11298	12500	14135	15550
	Plainfield	8884	9900	11240	12300
	Pomfret	2136	2300	2410	2545
	Putnam	8412	8400	8400	8400
	Scotland	684	820	940	1070
	Sterling	1327	1700	2115	2510
	Thompson	6217	6800	7690	8420
	Windham	16793	17400	18140	18810
	Woodstock	3177	4000	5210	6230
		District Totals			
	42 Towns	281,825	321,881	361,105	400,915

---

[8] Economic Profiles, Market Research Staff, Hartford National Bank & Trust Co., Hartford, Connecticut 1967.

VII. SOCIAL AGENCY OFFICES IN THE NORWICH DISTRICT[9]

A. Private Agencies and Locations

1. The American Cancer Society: branch offices in New London, Norwich, Putnam, and Willimantic.
2. Children's Services of Connecticut: branch office in New London
3. The Connecticut Association for Retarded Children has the following affiliations: New London County ARC (New London), Quinebaug Valley ARC (Putnam- Danielson), Windham County ARC (Willimantic).
4. The Connecticut Association for Mental Health: branch offices in Norwich and Willimantic.
5. The Connecticut Heart Association: chapters in New London, Norwich, Putnam and Willimantic.
6. The National Foundation for Diseases of the Central Nervous System maintains the New London Chapter in Norwich and the Windham County Chapter in Danielson.

B. Public Agencies and Locations

1. Office of Economic Opportunity is affiliated with these following agencies: Windham Area Community Action Program, serving the Willimantic and Danielson Labor Market Areas, and the Thames Valley Council for Community Action, serving the Norwich and New London Labor Market Areas.
2. The State Welfare Department: District Office #4 in Norwich.
3. The Division of Vocational Rehabilitation: District Office in Norwich; local offices, Mansfield State Trianing School, Norwich State Hospital, the Seaside Regional Center and New London.
4. The Connecticut State Employment Service; local offices in Danielson New London, Norwich, and Willimantic.
5. The Crippled Children's Section of the State Department of Health holds one-per-month clinics at the William Backus Hospital in Norwich, the Day-Kimball Hospital in Putnam, and the Windham County Memorial Hospital in Willimantic.
6. The Office of Tuberculosis Control, State Department of Health, offers out-patient services at the following locations: Health Department, New London; United Workers Building, Norwichtown; Uncas-on-Thames Hospital, Norwich, Day-Kimball Hospital, Putnam, and Eastern Connecticut State College, Willimantic.
7. The State Department of Mental Health operates a Child Guidance Clinic in Norwich, and provides an out-patient clinic for ex-patients of the Norwich State Hospital at the William Backus Hospital in Norwich.

---

[9] Data Sources: Directory of Rehabilitation Resources in Conn., Ed. R.W. Bain, State DVR, Hartford, Conn., 1966; Cooperative Area Manpower Planning System Report, Fiscal Year 1968, State of Connecticut.

NORWICH REGIONAL REPORTS

REPORT OF SUB-COMMITTEE ON DISABILITIES

STATEWIDE PLANNING PROJECT FOR VOCATIONAL REHABILITATION SERVICES

The Norwich District of the Statewide Planning Project for Vocational Rehabilitation Services includes 42 towns and cities in eastern Connecticut. The total area of these towns is 1403 square miles, 28.0 percent of the total area of the State. The population, by 1967 estimate of the State Department of Health is 332,510, 11.3 percent of the population of the entire State (almost identical with the 11.2 percent of the State population found in the same area in the 1960 census). This gives in 1967 a population density of 237 persons per square mile in the Norwich district, compared with a population density of 585 persons per square mile for the entire State. According to census figures the average annual rate of growth in the decade from 1950 to 1960 was in the Norwich district 2.57 percent and for the entire State 2.63 percent. Only three of the towns in the Norwich district had by 1967 estimate of the State Department of Health a population greater than 20,000. These were Groton (35,500), New London (33,100), and Norwich (41,600). Twenty-five of the towns had an estimated population of less than 5,000. The projected population for the area, according to the "regional profile" provided by the Statewide Planning Project is 361,105 by the year 1970 and 400,915 by 1975.

The 42 towns of the Norwich district in this planning project include all of the towns of New London County and all of the towns of Windham County, plus six towns of Tolland County and one of Hartford County. It is interesting, therefore, to compare some of the census findings of 1960 in New London and Windham Counties with the findings in Fairfield and Hartford Counties, two of the more populous counties in the State. The following figures are all taken from the "Town and County Fact Book, 1960". (1)

	New London County	Windham County	Fairfield County	Hartford County
Population	185,745	68,572	653,589	689,555
Median income of families	$6,337	$5,893	$7,371	$7,054
Percent of families with:				
Less than $3,000 income	12.5	15.0	9.3	8.7
$10,000 or more income	16.8	11.5	29.1	22.1
Average annual rate of growth (percent) 1950-1960	2.83	1.10	2.96	2.78
Percent of population:				
Non-white	2.9	0.6	5.3	4.7
Median education of population age 25 and over	10.7	8.9	11.6	11.0
Percent of labor force unemployed	4.1	6.2	3.9	4.6
Percent of those employed who are "blue collar" workers	53.9	62.8	46.5	47.9

These figures serve to indicate that the people of the Norwich district in the planning project may differ from the people in the rest of the State. Their numbers are less. They are more scattered in their land. The median income of their families is less and there are more families with a small income and fewer families with a large income than in Fairfield and Hartford Counties. The non-white population is less. In the northern part of the district (Windham County) the average annual rate of growth and the median education of the population are considerably less, and the rate of unemployment considerably higher, than in the other areas on which figures are given. Both New London and Windham Counties have a higher percentage of "blue collar" workers than Fairfield and Hartford counties.

These figures, however, do not in any way indicate that the incidence of disability and the need for vocational rehabilitation is any less in eastern Connecticut than in any other part of the State.

It has been impossible in the time allotted for this planning project to conduct any surveys or sampling procedures in order to form an estimate of the number of people in the area who are afflicted with some disabling condition and who are eligible for and would benefit from vocational rehabilitation services. To form any estimate of the numbers involved it has been found necessary to use incidence or prevalence rates derived from other studies and apply these to the population of the area.

According to estimates derived from the National Health Survey 9.2 percent of the population in Connecticut suffers from some limitation of activity due to chronic conditions. Applied to the Norwich district, this would mean that in 1967 there were 30,591 people with some limitation of activity because of a chronic illness. In 1970 there would be 33,222 such people in the area, and by 1975 there would be 36,884. If even 20 per cent of these people in 1975 are eligible for and can obtain vocational rehabilitation services this will mean that 7,377 people will be receiving service.

The Harbridge House Report, (3) a report made by the consulting firm of Harbridge House in 1966, gives estimates of the total numbers and rates per 100,000 population and of the incidence and rates per 100,000 of the disabled eligible for vocational rehabilitation services in eight of the standard VRA classes of disability in Connecticut. When these rates are applied to the population of the Norwich district the following table may be constructed:

Table I - Disability in Norwich District
(Constructed from Harbridge House Report)

Type of Disability VRA Classification	Total Incidence Rate*	1967	1970	1975	Incidence of Eligible Cases Rate*	1967	1970	1975
Orthopedic	2160	7182	7800	8660	790	2627	2853	3167
Visual #2	560	1862	2022	2245	69	229	249	277
Hearing	360	1197	1300	1443	120	399	433	481
Respiratory	690	2294	2492	2766	140	466	506	561
Mental Retardation	3000	9975	10833	12027	660	2194	2383	2646
Mental Illness	1260	4190	4550	5052	150	499	542	601
Epilepsy	830	2760	2997	3328	83	276	300	333
Cardiac	2300	7648	8305	9221	112	372	404	449
Total		37108	40299	44742		7062	7670	8515

*Rate per 100,000 population according to Harbridge House report.

The Harbridge House report makes no attempt to estimate the number of people in the "all other" VRA class of disability. Even without these people, more than 7,000 people in eastern Connecticut in 1967 were eligible for vocational rehabilitation services, and more than 8,500 will be eligible in 1975.

Some attempt may be made to form an estimate of a few of the people who might be included in the "all other" VRA classification for which the Harbridge House report gives no estimate.

The "Arthritis Source Book" of the U.S. Public Health Service, published in April 1966, estimates that the overall rate of arthritis and rheumatism in the United States is 69.6 per 1,000. Applying this rate to the Norwich district would mean that in 1967 there were 23,143 persons suffering from arthritis and rheumatism; by 1975 there will be 27,904 persons with these disorders. The Arthritis Source Book reports that the major occupation of 79.0 percent of these people is "work" or "keeping house" (who might, therefore, be of an age eligible for vocational rehabilitation), and that 5.5 percent of them are totally unable to carry on their usual activity and 14.9 percent are limited in their major activity. We find then that in 1967 in the Norwich district, 1,006 of those who "work" or "keep house" were totally unable to carry on their usual activity, and 2,724 were limited in their usual activity; by 1975, 1,212 will be totally unable and 3,284 will be limited. If even 20 per cent of these people are eligible for vocational rehabilitation, this will add another 899 people who must receive service in 1975.

In 1964 a five-year program for the care of the chronically ill in Connecticut was prepared by the State Department of Health(5). At that time it was estimated that there were in the entire State of Connecticut 380 cases of muscular dystrophy, myotonia and myasthenia gravis, 1,200 cases of paraplegia, 1,200 cases of mutiple sclerosis, 8,000-10,000 cases of cerebral palsy and congenital deformities of the neuraxis, and 5,000 cases of Parkinsonism.

If 11.3 percent of these cases lived in the Norwich district, there would in 1964 have been 43 cases of muscular dystrophy, myotonia and myasthenia gravis, 136 paraplegics, 136 people with multiple sclerosis, 904-1,130 persons with cerebral palsy and congenital deformities of the neuraxis, and 565 people with Parkinsonism. This would have added in 1964 at least 1,784 people in the Norwich district who had chronic illnesses for which vocational rehabilitation might have been desirable. By 1967, a conservative estimate of a least 2,000 such people might be made. Again, if even 20 percent of these people were considered eligible for vocational rehabilitation, another 400 would have been added to the rolls in eastern Connecticut in 1967, and more will be added by 1970 and 1975. Thus, at least 1300 people in the "all other" category will be eligible for vocational rehabilitation services by 1975.

In addition to the estimates of the numbers of people with physical disabilities for whom vocational rehabilitation is urgently needed, there are others who might benefit by these services. The State Jail located in Montville accomodates at any one time 107 men and 16 women; and the State Jail in Brooklyn, 86 men 0 women. The Connecticut State Farm for Women, which, however, draws from all over the State, had on January 1, 1967, 120 inmates. Many of these people, also, might be eligible for vocational rehabilitation services.

In anticipation of future needs it might be noted that in the 1967-68 school year the Bureau of Pupil Personnel of the State Department of Education reported that in the area there were 18 classes, averaging 10 pupils each, for the trainable mentally retarded and 52 classes, averaging 15 pupils each, for the educable mentally retarded. This means there were approximately 180 children in trainable classes and 780 in educable classes.

The Bureau of Pupil Personnel also reported that in the 1966-67 school year 350 school children in the district received "Special Services" (psychological, social work, and other non-instructional services), and 94 children were enrolled in special instructional programs (special classes, homebound programs, resource room instruction, and itinerant teacher instruction). All of these children might represent future candidates for Vocational Rehabilitation Services.

The Waterford Country School, a residential treatment school for multiply-handicapped children, has an enrollment of 54 children, most of them from Connecticut.

The Mystic Oral School, a State school for the deaf, located in Mystic and serving pre-school through high school age students, has an average attendance of 150 (these, however, drawn from all parts of the State).

The number of boys and girls from the Norwich district passing through the Juvenile Courts of Connecticut must also be considered in assessing vocational rehabilitation needs. The second district of the Juvenile Courts, which includes the Norwich district, processed 2934 boys and 692 girls in 1965.

While most of the children mentioned in the above few paragraphs are not yet eligible for Vocational Rehabilitation Services, it is obvious that many of them will within the next few years require vocational evaluation or rehabilitation. To their numbers must be added the adults now living in the area who will suffer disabling accidents, strokes, amputations, debilitating disease, etc.

To meet the needs of this substantial group of people, some services are available.

The Vocational Rehabilitation Section of the State Department of Education, with offices in Norwich and New London, had in 1966-67 an active case load of 835 people, and counted 212 people as "closed, employed" during the year. This "active case load" was apparently about 10% of the eligible cases according to estimates of the number eligible previously cited.

The Connecticut Society for Crippled Children and Adults, Inc. opened a regional office in southeastern Connecticut in 1966. In 1967 a pre-vocational evaluation program was established in this center. By 1970 it is estimated that approximately 125 persons per year will be processed through this program, and that other vocational programs will be available. Physical therapy, occupational therapy, social services - as well as other related rehabilitation services - are available through this center.

Serving the people of the Norwich district there are four general hospitals; the Day-Kimball Hospital in Putnam with 142 beds; the Windham Community Memorial Hospital in Willimantic with 153 beds; the William W. Backus Hospital in Norwich with 186 beds; and the Lawrence and Memorial Hospitals in New London with 327 beds. This gives, in 1967, a total of 808 beds available in general hospitals in the area - hospitals which are also serving the acute needs of the area and which can necessarily spend little time and few beds on people needing vocational rehabilitation.

In the area there is also a chronic disease hospital, Uncas-on-Thames in Norwich, with 102 beds devoted to tuberculosis patients and 146 beds for chronic disease patients. For the mentally ill, the Norwich Hospital in Preston can accomodate 2,538 patients - these patients being drawn from all of eastern Connecticut and some parts of Middlesex and Hartford Counties.

Also in the area in 1967 there were 32 licensed chronic and convalescent nursing homes, with a total bed capacity of 1,524. Many of the patients in these facilities are quite old and would not be considered suitable for vocational rehabilitation. But, for those who may be, no services are offered.

Two regional centers for the mentally retarded are located in the Norwich district. The more recently established one, located in Putnam, thus far offers only a day care program including a small sheltered workshop. Services of this center will be expanded in the near future. The Seaside Regional Center for the Mentally Retarded in Waterford was opened in May 1961. It has a bed capacity of 240 and serves an area in southeastern and south-central Connecticut. Among other services Seaside has developed a comprehensive vocational training program for the teenage group living at home or at Seaside. About 83 young people are participating in this program. Additionally, 42 young men and women who appear to possess the potential for independent living, but who thus far have been unable to bridge the gap are receiving the benefits of a trainee program at Seaside.

Day care programs are conducted by Seaside at four places in the Norwich district; at Seaside, at Uncas-on-Thames Hospital, in Groton, and in North Stonington. Another thirty-three people are served in a sheltered workshop at Seaside - and a sheltered workshop, serving about 25 people, is located in Preston.

The Mansfield Training School, serving all of eastern Connecticut, has a bed capacity of 1750. It provides a workshop program for approximately 150 persons, a work training program for about 70 people who live at home and can commute to the school, and a cooperative work training program with the Tolland jail in which about 20 prisoners receive training at Mansfield.

The Southeastern Connecticut Hearing and Speech Center located in Groton was opened in 1966. It provides diagnostic services plus speech therapy and auditory training. Approximately 70 percent of the caseload of this facility are children but services are also available for adults. It is estimated that by 1970 this center will be able to handle an annual caseload of 200.

Limited speech and hearing services are available also through the University of Connecticut. Patients accepted for these services are primarily those who will provide a learning experience for students.

Other rehabilitation services for adults in the Norwich district include:

The American Cancer Society with units in Putnam, Norwich and New London whose services include financial assistance for diagnostic and therapeutic procedures and prosthetic devices, speech therapy and other rehabilitation aids.

Connecticut State Labor Department with offices in New London, Norwich, Danielson and Putnam.

The National Multiple Sclerosis Society with an office in New London which provides wheel-chairs and special equipment to patients with multiple sclerosis.

The New London County Tuberculosis Association with an office in New London lends intermittent positive pressure breathing equipment to patients under certain conditions.

Some services not located in the Norwich district, but to which residents of the district may apply for assistance include the Arthritis Foundation, Connecticut Chapter in Hartford; the Connecticut Board of Education and Services for the Blind in Wethersfield; the Muscular Dystrophy Association with offices in New Haven and Hartford; the Veteran's Administration which has a regional office in Hartford; and the Gaylord Hospital in Wallingford.

Not directly a part of Vocational Rehabilitation Services, but perhaps having an effect on them in a preventive manner are the services for children in the district. These include the services of the Crippled Children's Section of the State Department of Health, the United Cerebral Palsy Assocation, the National Foundation, the Child Guidance Clinic of Southeast Connecticut, the Child and Family Services of Connecticut with an office in New London, the United Workers Family and Children's Services, Catholic Charities, Family Service of New London, the State Welfare Department, and many others.

The sub-committee on disabilities makes the following recommendations:

1) The need for more diagnostic centers should be determined.

2) Establishment of more sheltered workshops as part of a comprehensive plan. This should be done with continued co-operative planning among all interested segments in the community.

3) Consideration should be given to providing transient living facilities near the rehabilitation facility.

4) A means of transportation should be made available to enable selected clients to get to facilities.

5) More work adjustment and on the job training situations should be provided.

6) More trained counselors and other qualified rehabilitation personnel are needed.

7) There should be more effective co-operation between visiting agencies and facilities.

8) An education program for the public, the business and industrial community and professional groups. All need to become more involved.

9) The planning and execution of the items listed above should be coordinated with other comprehensive planning groups: i.e. Mental Retardation, Mental Health, Comprehensive Health Planning, etc. This can perhaps, be done through the Social Planning Council of the United Fund and Services or the Health Council.

PLANNING COUNCIL FOR VOCATIONAL REHABILITATION SERVICES

1. Internship expanded - State rehabilitation counselors have traditionally handled the physically disabled individual, and only until comparatively recently have they begun working with the mentally retarded. They have emancipated themselves from a historical emphasis on medical aspects, and, when presented with a retarded client, lack both knowledge of retardation and the proper attitude toward it, and have not confidence that they can be effective in placing retardates. The counselor needs to have a commitment to the idea that the retardate should and can be placed, and should be willing to exert much energy in his efforts to be of help to the retardate in achieving his vocational adjustment. There is no better means of knowing what retardation is than to do an internship at a center or institution for the mentally retarded. Hopefully, at the end of the internship period, the counselor will understand the human problem associated with retardation, will strongly know that retardates can be vocationally successful, and will feel that he can be successful in placing them.

2. The rehabilitation counselor should be familiar with occupational information, since, if he becomes acquainted with it, the counselor will be more effective in counseling, training, and placement of the retarded. It is not enough to know what jobs are available in the community. The counselor has to know what the job entails and under what conditions the retarded will have to work. If the counselor knows the methods of obtaining occupational information such as job analysis, what goes on in the various industries, etc., and has received training in what the occupation is and how it is developed, he knows what placement is all about and is more selective in obtaining suitable job placement.

3. There should definitely be more in-service training for rehabilitation counselors, particularly in regard to new legislation, policies, and programs in regard to how they effect the retarded individual. The purpose of the in-service should be to acquaint the counselor with the worth of clients and how new legislation, policies, and programs can best be used to serve them, not on administration process for its own sake.

4. One of the most serious gaps in the State Vocational Rehabilitation program is the vocational preparation of the retardate in the school systems. They do not provide any, or enough, services to this group solely because the DVR feels the retardate in the school system is the responsibility of the school. Whose responsibility is the retardate if he quits school? An agreeable program should be developed between DVR and the school systems and each school system that conducts special education classes for the retarded should have a counselor assigned to it. There are many school systems that are willing to have vocational programs for the retarded and with the help of DVR could prepare the retarded students for employment.

RECOMMENDATIONS FOR INTER-AGENCY COOPERATION

1. Divide the State into regions and solicit from each service agency an individual to be a representative on a regional council. The purpose of the council would be to discuss problems.

2. Yearly or bi-yearly institutes or conferences should be held. These should also be on a regional basis. They would be good for each agency to discuss the function, service, etc. of the agency.

REPORT OF VOCATIONAL TRAINING SUB-COMMITTEE OF THE NORWICH REGIONAL COMMITTEE OF THE STATEWIDE PLANNING PROJECT FOR VOCATIONAL REHABILITATION SERVICES

The Vocational Training Sub-Committee has been assigned the task of compiling information necessary to accomplish three specific objectives of the Statewide Plan:

1. To identify the barriers that prevent or delay needed vocational rehabilitation services for the handicapped. This was accomplished by asking twenty-two area agencies and institutions how they felt that DVR services could be improved. The following points were brought to our attention:

    a. Lack of funds for Client Services

    b. Lack of staff for Division of Vocational Rehabilitation

        1) inadequate follow-through
        2) too great a time lapse between referral and action by DVR

    c. Problem in finding means of transportation for client to obtain rehabilitation services

    d. Counselor education necessary in community sources of service

    e. Greater utilization of voluntary agencies

    f. Less emphasis on DVR system of showing progress by changing case status, and more emphasis on the needs of the individual

2. To prepare a written plan which will identify, analyze, and evaluate program goals, the staff and financial support needed to achieve these goals, with full geographic coverage of all programs offering vocational rehabilitation services.

It was decided that the same twenty-two agencies or institutions contacted would be asked the following seven questions:

1. Does the Division of Vocational Rehabilitation use your services? Have they ever used your services in the last?

    The services of 12 agencies are used by DVR.
    The services of 6 agencies have never been used by DVR.
    Three cooperative agencies have workshops and on-the-job training stations which are used by DVR.

2. Identify the number of clients who can be serviced at any given time. Specify the kind of service provided and whether it is pre-vocational,

vocational, or follow-up, or a combination of the above.

Pre-vocational services offered and number of agencies offering them:

full services	2
full or partial (unspecified)	1
medical diagnosis	2
equipment loan	1
education	1
transportation	1
financial aid	2
medical treatment (includes payment of physician's fees, hospital bills, clinic fees)	6
pre-vocational evaluation	3
workshops	1
occupational training	1
hearing and/or speech therapy	2
occupational therapy	2
physical therapy	3
psychological counseling	1
counseling	3

Vocational services offered and number of agencies involved:

full services	1
full or partial (unspecified)	2
job placement	2

Follow-up services offered and number of agencies doing this:

full service	1
full or partial (unspecified)	3
social services	1
counseling	1

Other services offered and number of agencies offering them:

public education and information	1
counseling, adoption, foster home care, and referral	1
family counseling	2
children's services	1
camping and recreation	1
homemaker service	1

Number of clients served at any one time in the various reporting agencies is as follows:

varies greatly
$300 per patient (number depends on budget)
100-150
400 cases per year
12 cases per day
unlimited & pre-vocational evaluation, 7
no answer
1967, 623 cases
100-150 - does not include follow-up

Number of clients served (cont.)

75
2,000 patients (4,000 admissions;
  1/2 readmissions)
undetermined number in program;
  10 in discussion in 3 months
40
400
222
181
no maximum
number depends on available space
80

3. Identify the approximate percentage of DVR clients being serviced at this time.

   3 - no information available
   8 - 0%
   1 - less than 1%
   2 - 1%
   1 - 3%
   1 - 8%
   1 - 30%
   1 - less than 34%
   1 - pre-vocational evaluation - 100%
       P.T. & O.T. patients - 1%

4. Identify whether any available service within the agency or institution is not being used at full capacity. If this is the case, explain why the service is not fully utilized.

   13 - being used to full capacity
   2 - no answer
   1 - agency's out-patient P.Y. & O.T. and pre-vocational evaluation are not being used to full capacity due to lack of referrals, lack of funds, and newness of program
   1 - could provide service to more clients if transportation were available
   1 - hearing, speech, and aphasia program not used to full capacity
   1 - highest patient ratio or turnover

5. If the need for additional services, similar to those already provided by the agency or institution, were documented, could your facilities be increased; could more staff be hired?

   7 - unqualified "yes" to both
   1 - probably
   2 - "yes" - with financial support
   1 - "yes" - additional staff and facilities could both be used.
   1 - counseling and clerical staff could be increased.
   1 - facilities could not be increased; staff could be.
   1 - facilities need not be increased; more staff could be hired.
   1 - "no" to both
   1 - "no" - because of lack of money
   1 - no answer
   1 - "yes" - for additional preventive service
   1 - no staff - all voluntary

6. Are the services which you provide available directly within your agency or institution, or are some of your services purchased?

   14 - all service directly available. (One may purchase some in the future.
   1 - all services available, but consultants are used.

1 - utlizes programs of Department of Labor
1 - has all services available, but may purchase additional services (i.e., specialist)
1 - purchases maternity shelter and care
1 - available: clinics, P.T., O.T., speech therapy, & social services. Purchases: some O.T., P.T., and some clinical.

7. Are your services free, so you have a flat rate, or do you have a sliding scale based on the client'a ability to pay?

    11 - provide all services free (one has a sliding scale for some services; one has a sliding scale for adoption service.)
    5 - provide services on a sliding scale
    2 - flat rate
    1 - group of three cooperative agencies provides free service to community residents, except one agency in group which is on a sliding scale.

We have agreed to tabulate the extent of services provided under three main categories:

1. Pre-Vocational Services: Diagnostic services (physical, psychological and pre-vocational evaluation), physical medicine (physical therapy, including hearing & speech therapy, psycho-therapy, and occupational therapy), occupational training (institutional training and OJT), pre-employment counseling and guidance, and pre-employment social services.
2. Vocational Services: Job placement, vocational counseling of client who has been placed, social services
3. Follow-Up: Counseling and guidance, social services

3. To identify vocational rehabilitation sources required to meet future requirements, including necessary legislative action, community support, costs, and steps required to facilitate the achievments of statewide programs at State and local levels.

    1. more money
    2. better qualified staff
    3. more time to organize and implement programs
    4. community support, education, and interest

NORWICH REGIONAL COMMITTEE

Chairman

Earl Peters
Supervisor of Vocational Rehabilitation
Seaside Regional Center, Waterford

George Ambulos, Counselor
Connecticut State Employment
Service

Samuel Bean, Employment Counselor
Connecticut State Employment
Service, Norwich

Joseph A. Capon, Association
Director, United Fund Community
Service of South Eastern Connecticut

Joseph Carano
Division of Vocational Rehabilitation
Bureau of Community & Institutional
Services, Hartford

Mark Driscoll
State Welfare Department, Norwich

Donald Farrington, Executive
United Workers of Norwich

Kenneth Gunderman
Thames Valley Council for Community
Action, New London

Mrs. Prudence Kwiecien
Information and Referral Director
Quinebaug Valley Services of Health
& Welfare, Putnam

Roger Newcomb
Easter Seal Center, Uncasville

Joseph Portelance, Supervisor
Physical Therapy Department
Uncas-On-Thames, Norwich

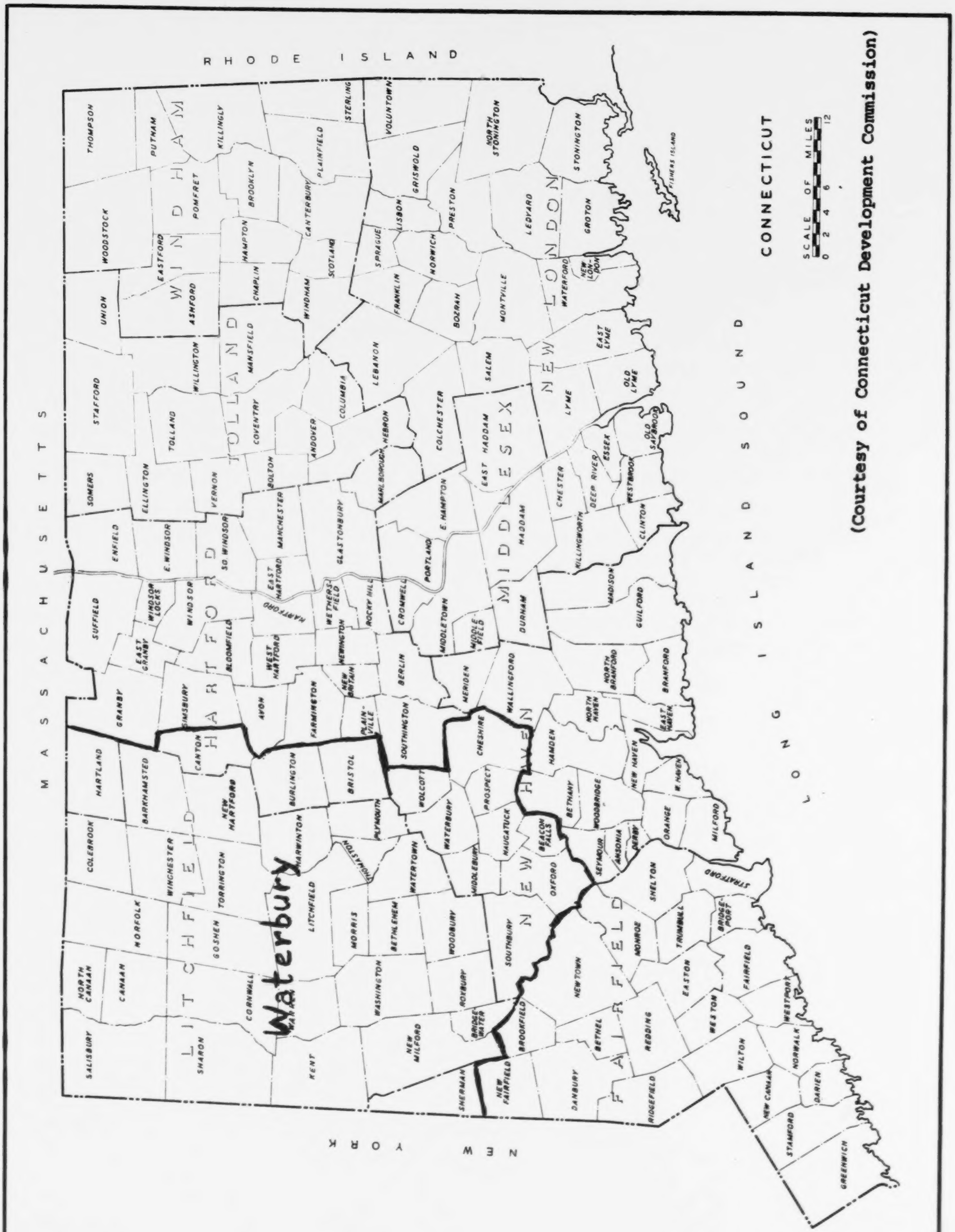
Dr. Mila Rindge, Director
South Eastern Regional Center
Mansfield Training School

Thomas Ulrich, Director
Easter Seal Center, Uncasville

Clay White, District Supervisor
Division of Vocational Rehabilitation,
Norwich

Mrs. Brenda Williams
Thames Valley Council, New London

Hollis Shaw
Rehabilitation Program Coordinator
Mansfield Training School


CONNECTICUT
SCALE OF MILES
0 2 4 6 12
Waterbury
MASSACHUSETTS
RHODE ISLAND
NEW YORK
LONG ISLAND SOUND
FISHERS ISLAND
LITCHFIELD
HARTFORD
TOLLAND
WINDHAM
NEW LONDON
MIDDLESEX
NEW HAVEN
FAIRFIELD
SALISBURY
NORTH CANAAN
CANAAN
NORFOLK
COLEBROOK
HARTLAND
GRANBY
SUFFIELD
ENFIELD
SOMERS
STAFFORD
UNION
WOODSTOCK
THOMPSON
PUTNAM
KILLINGLY
POMFRET
EASTFORD
ASHFORD
WILLINGTON
TOLLAND
ELLINGTON
E. WINDSOR
WINDSOR LOCKS
EAST GRANBY
SHARON
CORNWALL
GOSHEN
TORRINGTON
WINCHESTER
BARKHAMSTED
NEW HARTFORD
CANTON
SIMSBURY
BLOOMFIELD
WINDSOR
SO. WINDSOR
VERNON
MANSFIELD
CHAPLIN
HAMPTON
BROOKLYN
CANTERBURY
PLAINFIELD
STERLING
VOLUNTOWN
GRISWOLD
LISBON
SPRAGUE
SCOTLAND
WINDHAM
COVENTRY
ANDOVER
COLUMBIA
BOLTON
MANCHESTER
EAST HARTFORD
HARTFORD
WEST HARTFORD
AVON
FARMINGTON
BURLINGTON
HARWINTON
LITCHFIELD
WARREN
KENT
WASHINGTON
MORRIS
BETHLEHEM
THOMASTON
PLYMOUTH
BRISTOL
PLAINVILLE
NEW BRITAIN
NEWINGTON
WETHERSFIELD
GLASTONBURY
ROCKY HILL
CROMWELL
PORTLAND
E. HAMPTON
MARLBOROUGH
HEBRON
LEBANON
FRANKLIN
NORWICH
PRESTON
NORTH STONINGTON
STONINGTON
LEDYARD
GROTON
NEW LONDON
WATERFORD
MONTVILLE
BOZRAH
COLCHESTER
SALEM
EAST LYME
OLD LYME
LYME
EAST HADDAM
HADDAM
CHESTER
ESSEX
DEEP RIVER
OLD SAYBROOK
WESTBROOK
CLINTON
KILLINGWORTH
MADISON
GUILFORD
DURHAM
MIDDLETOWN
MIDDLEFIELD
MERIDEN
BERLIN
SOUTHINGTON
WALLINGFORD
CHESHIRE
WOLCOTT
WATERBURY
WATERTOWN
WOODBURY
ROXBURY
NEW MILFORD
SHERMAN
NEW FAIRFIELD
BRIDGEWATER
BROOKFIELD
SOUTHBURY
MIDDLEBURY
NAUGATUCK
PROSPECT
BEACON FALLS
OXFORD
SEYMOUR
ANSONIA
DERBY
BETHANY
HAMDEN
WOODBRIDGE
NORTH HAVEN
NORTH BRANFORD
BRANFORD
EAST HAVEN
NEW HAVEN
W. HAVEN
ORANGE
MILFORD
SHELTON
STRATFORD
NEWTOWN
MONROE
TRUMBULL
BRIDGEPORT
DANBURY
BETHEL
REDDING
EASTON
FAIRFIELD
WESTON
WESTPORT
RIDGEFIELD
WILTON
NORWALK
NEW CANAAN
DARIEN
STAMFORD
GREENWICH

(Courtesy of Connecticut Development Commission)

[1] Map of Waterbury Region

PROFILE OF WATERBURY REGION

I. Rationale for Districting

a) The State Division of Vocational Rehabilitation originally conceived the Waterbury District for administration and provision of rehabilitation services for residents of its forty towns.

b) The area is topographically and economically homogeneous. Most of the residents of this area work within the cities and towns of the Waterbury District[2].

c) Sub-divisions of this district are frequently taken together as intra-state regions for other planning purposes.

II. Transportation Patterns[3]

Interstate 84 and Connecticut Route 8 are the only major express highways in the Waterbury District, although additional significant north-south traffic is handled by U.S. 7 and Connecticut Routes 10 and 25, and significant east-west traffic is carried by U.S. 6, 44, 202, and Connecticut Routes 4 and 72.

Due to the Waterbury District's relatively unique geographical location, on the periphery of the state's major traffic corridors, it accomodates little of the interstate travel which passes through Connecticut.

There is almost no public transportaion between towns in the Waterbury Labor Market Area and public transportation within the City of Waterbury is limited, thus making it difficult for the economically disadvantaged to commute to places of employment.[4] A similar situation may exist in other parts of the Waterbury District, particularly the Bristol Labor Market Area.

III. Topography[5]

The Waterbury District lies entirely within the geographic region known as the Western Uplands. This area is heavily forested and its many hills and valleys create some of the State's most scenic landscapes. The Western Uplands slope from 2,000 feet in altitude in Salisbury and Canaan to the State's southern shore.

The rocky nature of the soil and the steepness of the land have limited widespread urban development, confining it principally to the valley areas close to the Housatonic and Naugatuck Rivers and their tributaries.

[2] Commuting Patterns in Connecticut, Connecticut Department of Labor, Hartford, Connecticut, 1966.

[3] Transportation, Connecticut Interregional Planning Program, Hartford Connecticut, 1966.

[4] Cooperative Area Manpower Planning System Report (CAMPS), Connecticut Department of Labor, Hartford, Connecticut, 1967, pg. 277.

[5] Connecticut Takes Stock for Action, Connecticut Interregional Planning Program, Hartford, Connecticut, 1964.

IV. Economic Data

The majority of the employees in the Waterbury District work in manufacturing. Historically, this may be attributed to the growth of small mill towns in the area into complex cores of industrial activity. However, it is important to note that the labor force is expected to increase greatly by 1975. If the present trend is continued, it is possible that employment opportunities may not be adequate to the demand for jobs.

LABOR MARKET INFORMATION[6]

Area		Non-Agricultural Employment		
	Mfg.	Non-mfg.	Govt.	Total
Waterbury District Totals	62790	48780	12820	126400

	Unemployment			
Men	Women	Total	Ratio to Labor Force
3960	4830	8790	6.9%

---

[6] Connecticut State Employment Service. Data are for quarter ending June 30, 1968.

The Waterbury District includes 7 towns of the Danbury Labor Market Area. The figures above reflect 10% of the Danbury Labor Market information, which approximately describes the employment contained within these towns of the Waterbury District.

TOTAL NONAGRICULTURAL EMPLOYMENT

Bristol Area - June 1968

INDUSTRY	June 1968	March 1968	% Change June 1968 over March 1968	June 1967
Total Nonagricultural Employment	18,490	17,950	+ 3.0	18,610*
Manufacturing	10,460	10,480	- 0.2	11,110*
Fabricated Metals	2,990	2,940	+ 1.7	3,270
Machinery	3,200	3,120	+ 2.6	3,260
Electrical Equipment	1,400	1,420	- 1.4	1,730
Instruments, Watches & Clocks	1,220	1,310	- 6.9	1,140*
**Other Manufacturing	1,650	1,690	- 2.4	1,710
Nonmanufacturing	8,030	7,470	+ 7.5	7,500*
Construction	680	500	+36.0	570*
Transportation (Inc. R.R.)	130	170	-23.5	90
Communications & Utilities	290	290	0.0	260
Trade	2,930	2,800	+ 4.6	2,890
Wholesale	260	250	+ 4.0	250
Retail	2,670	2,550	+ 4.7	2,640
Finance, Ins. & Real Estate	420	400	+ 5.0	410
Service (Inc. Nonprofit)	1,910	1,690	+13.0	1,730
Government	1,670	1,620	+ 3.1	1,550

**Other manufacturing includes firms in the food, textiles, lumber and wood, paper, printing and publishing, chemicals, stone, clay and glass, primary metals aircraft parts and sporting goods.

*Excludes workers involved in labor-management disputes.

Unemployment - Bristol Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	1,600	7.3%	600	1,000
May	1968	1,400	6.7	490	910
April	1968	1,400	6.7	630	770
March	1968	1,500	6.9	740	760
December	1967	1,200	5.7	440	760
June	1967	1,200	5.7	740	460

TOTAL NONAGRICULTURAL EMPLOYMENT

Torrington Area - June 1968

INDUSTRY	June 1968	March 1968	% Change June 1968 over March 1968	June 1967
Total Nonagricultural Employment	24,520	23,710	+ 3.4	24,200**
Manufacturing	11,020	10,870	+ 1.4	11,080**
Textiles and Apparel	660	600	+10.0	650
Lumber and Furniture	720	810	-11.1	730
Primary Metals	620	620	0.0	730
Machinery	3,580	3,750	- 4.5	3,780
Electrical Equipment	1,590	1,390	+14.4	1,470
Instruments & Needles	1,800	1,730	+ 4.0	1,910
*Other Manufacturing	2,050	1,970	+ 4.1	1,810**
Nonmanufacturing	13,500	12,840	+ 5.1	13,120**
Construction	1,690	1,260	+34.1	1,530**
Transportation (Inc. R.R.)	310	310	0.0	300
Communications and Utilities	460	450	+ 2.2	460
Trade	4,170	4,090	+ 2.0	3,950
Wholesale	420	410	+ 2.4	450
Retail	3,750	3,680	+ 1.9	3,500
Finance, Ins. & Real Estate	590	550	+ 7.3	590
Service (Inc. Nonprofit)	3,370	3,180	+ 6.0	3,350
Government	2,910	3,000	- 3.0	2,940

*Other manufacturing includes firms in the food, paper, printing and publishing, chemicals, rubber, stone, clay and glass, fabricated metals, transportation equipment and miscellaneous manufacturing industries.

**Excludes those idled due to labor-management disputes.

Unemployment - Torrington Area

Midmonth	Total	Ratio to Labor Force	Men	Women
June 1968	1,600	5.2%	680	920
May 1968	1,300	4.4	500	800
April 1968	1,700	5.8	900	800
March 1968	1,700	5.8	1,060	630
June 1967	1,400	4.6	730	670

TOTAL NONAGRICULTURAL EMPLOYMENT

Waterbury Area - June 1968

INDUSTRY	June 1968	May 1968	% Change June 1968 over May 1968	June 1967
Total Nonagricultural Employment	79,730	78,120	+ 2.1	74,130**
Manufacturing	41,850	40,980	+ 2.1	38,190**
Food	1,230	1,210	+ 1.7	1,180
Textiles & Apparel	1,420	1,420	0.0	1,320
Printing & Publishing	1,000	970	+ 3.1	940
Chemicals, Rubber & Plastics	6,340	6,180	+ 2.6	2,660**
Primary Metals	6,420	6,240	+ 2.9	6,390
Brass	5,750	5,640	+ 2.0	5,690
Fabricated Metals	9,160	9,010	+ 1.7	9,340
Machinery	2,890	2,890	0.0	3,220
Electrical Equipment	2,140	2,110	+ 1.4	2,590
Clocks & Watches	2,530	2,390	+ 5.9	2,450
Instruments	2,650	2,670	- 0.8	2,630
*Other Manufacturing	6,070	5,890	+ 3.1	5,470
Nonmanufacturing	37,880	37,140	+ 2.0	35,940**
Construction	2,980	2,720	+ 9.6	2,750**
Transportation (Inc. R.R.)	1,550	1,550	0.0	1,530
Communications & Utilities	1,540	1,480	+ 4.1	1,450
Trade	12,260	12,150	+ 0.9	11,690
Wholesale	2,180	2,170	+ 0.5	1,950
Retail	10,080	9,980	+ 1.0	9,740
Finance, Ins., & Real Estate	2,000	1,970	+ 1.5	1,860
Service (Inc. Nonprofit)	9,870	9,630	+ 2.5	9,260
Government	7,680	7,640	+ 0.5	7,400

*Other manufacturing includes firms in the ordnance, tobacco, lumber and wood, furniture and fixtures, paper, stone, clay and glass, transportation equipment, and miscellaneous manufacturing industries.

**Does not include workers idled due to labor-management disputes.

Unemployment - Waterbury Area

Midmonth		Total	Ratio to Labor Force	Men	Women
June	1968	5,400	5.9%	2,600	2,800
May	1968	4,700	5.1	2,200	2,500
April	1968	5,100	5.7	2,900	2,200
December	1967	3,800	4.2	1,800	2,000
June	1967	4,400	4.9	2,700	1,700

LABOR SUPPLY CLASSIFICATION
GROUP "C" MODERATE UNEMPLOYMENT
AS DESIGNATED BY THE U.S. DEPARTMENT OF LABOR

V. EDUCATIONAL AND HEALTH RESOURCES

A. Educational Resources[7]

1. Accredited Institutions of Higher Education
    - a) Public Junior Colleges
        1. Northwest Community College..................Winsted
        2. Mattatuck Community College..................Waterbury
        3. Waterbury St. Technical Institute............Waterbury
        4. University of Connecticut Branch.............Waterbury
    - b) Private Junior College
        1. Post Junior College..........................Waterbury
    - c) Other Private College
        1. Seat of Wisdom College.......................Litchfield
2. State Regional Vocational-Technical Schools
    - a) Oliver Wolcott Regional Voc.-Tech................Torrington
    - b) W. F. Kaynor Regional Voc.-Tech..................Waterbury
3. State-Aided Schools for the Disabled
    - a) Southbury Training School (MR)..................Southbury

---

[7] Connecticut State Department of Education; Educational Directory of Connecticut, Hartford, Connecticut, 1967.

PUBLIC SCHOOL SERVICES FOR EXCEPTIONAL CHILDREN [8]

WATERBURY REGION

TOWN	Learning Disabilities	Mental Retardation	Emotionally Disturbed	Physically Handicapped	Speech & Hearing	Gifted & Talented	Perceptually & Neurologically Impaired	Legally Blind & Partially Sighted	Social Work Services	Psychological Services
1. Barkhamsted		x							x	
2. Beacon Falls		x			x					
3. Bethlehem		x			x					
4. Bridgewater		x								
5. Bristol	x	x			x	x		x	x	x
6. Burlington		x								x
7. Canaan					x					
8. Canton	x	x	x				x			
9. Cheshire		x			x				x	x
10. Colebrook		x							x	
11. Cornwall										
12. Goshen		x								
13. Hartland		x							x	
14. Harwinton										x
15. Kent										x
16. Litchfield		x				x				x
17. Middlebury		x	x							x
18. Morris										
19. Naugatuck		x	x		x		x			x
20. New Hartford		x							x	
21. New Milford			x							x
22. Norfolk		x							x	
23. North Canaan										
24. Oxford			x							x
25. Plymouth	x	x								x
26. Prospect	x	x			x	x				
27. Roxbury		x								
28. Salisbury										
29. Sharon		x								
30. Sherman		x								
31. Southbury		x								
32. Thomaston	x	x								x
33. Torrington		x								x
34. Warren										
35. Waterbury	x	x	x	x	x					
36. Washington								x	x	x
37. Watertown	x	x								x
38. Winchester**		x			x				x	x
39. Wolcott	x	x			x				x	
40. Woodbury					x	x		x		x

---

[8] Connecticut State Department of Education, Bureau of Pupil Personnel and Special Education Services, Directory of Public School Services to Exceptional Children, 1967-1968.

B. Health Resources[9]

1. Locally Administered General Hospitals

a)	Bristol Hospital	Bristol
b)	New Milford Hospital	New Milford
c)	Sharon Hospital	Sharon
d)	Charlotte Hungerford Hospital	Torrington
e)	St. Mary's Hospital	Waterbury
f)	Waterbury Hospital	Waterbury
g)	Litchfield County Hospital	Winsted

VI. Population Data

As indicated on the following table, the Waterbury District is expected to add approximately 50,000 people to its current population by 1975.* This estimated increment, rough as it is, still gives a good indication of the growth to be expected in this District. As the general population increases, the disabled population also increases, and their needs for social and rehabilitation services will rise at a predictable rate. Even though the assessment of existing social services may not be 100% complete, it is clear that these services will have to be augmented to meet the needs and demands of an additional 50,000 people.

*Method of population projection:

The estimates (for 1970 and 1975) indicated on the following table do not take into account such variables as birth and death rates, changes in migration patterns, or fluctuations in employment opportunities. They are based on figures provided by the Connecticut State Department of Health and these data were treated in the following manner:

1. 1960 population subtracted from the 1966 population
2. this six-year population increase (or decrease) was divided by six to obtain the average annual increment (or decrement)
3. the average annual increment was multiplied by four and added to the 1966 population to estimate the 1970 population
4. the average annual increment was multiplied by nine and added to the 1966 population to estimate the 1975 population.

This is purely a linear projection.

---

[9] State of Connecticut, Register and Manual, Secretary of the State, Hartford, Connecticut, revised 1966.

POPULATION DATA

WATERBURY DISTRICT[10]

				STRAIGHT PROJECTION	
COUNTY	TOWN	1960	1965	1970	1975
Fairfield	Sherman	820	920	1120	1270
Litchfield	Barkhamsted	1400	1700	2065	2400
	Bethlehem	1500	1700	1835	2000
	Bridgewater	910	1100	1395	1635
	Canaan	790	830	890	940
	Colebrook	790	830	925	990
	Cornwall	1100	1100	1100	1100
	Goshen	1300	1400	1465	1550
	Harwinton	3300	3800	4470	5050
	Kent	1700	1700	1700	1700
	Litchfield	6300	7400	8470	9550
	Morris	1200	1500	2035	2450
	New Hartford	3000	3300	3500	3750
	New Milford	8318	10700	12955	15275
	Norfolk	1827	1900	2115	2260
	North Canaan	2836	2800	2775	2755
	Plymouth	8981	9600	10345	11030
	Roxbury	910	1300	1555	1870
	Salisbury	3309	3800	4300	4790
	Sharon	2100	2100	2270	2350
	Thomaston	5900	6500	7070	7650
	Torrington	30000	30400	31500	32250

				STRAIGHT PROJECTION	
COUNTY	TOWN	1960	1965	1970	1975
Litchfield	Warren	600	680	785	875
	Washington	2600	3000	3270	3600
	Watertown	14837	16100	17940	19500
	Winchester	15000	11100	11670	12250
	Woodbury	4000	4800	5500	6250
Hartford	Bristol	45499	51300	56170	61490
	Burlington	2800	3200	3635	4055
	Canton	4800	5600	6470	7300
	Hartland	1000	1100	1170	1255
New Haven	Beacon Falls	2900	3300	3570	3900
	Cheshire	13383	14900	16470	18000
	Middlebury	4800	5300	6135	6800
	Naugatuck	19500	21000	22335	23750
	Oxford	3300	3900	4635	5300
	Prospect	4400	5300	6070	6900
	Southbury	5186	6200	6450	7090
	Waterbury	107130	107500	108750	109560
	Wolcott	9000	11000	12670	14500

District Totals

DISTRICT	TOWNS				
Waterbury	40	344,499	371,620	399,550	426,990

---

[10] Economic Profiles, Market Research Staff, Hartford National Bank and Trust Company, Hartford, Connecticut, 1967.

VII. SOCIAL AGENCY OFFICES IN THE WATERBURY DISTRICT[11]

	Private Agencies	Location
1.	American Cancer Society	Torrington Waterbury
2.	Arthritis Foundation	Waterbury Hospital Clinic
3.	Children's Services of Connecticut	Torrington
4.	Mental Health Association of Northwestern Conn.	Torrington
5.	Connecticut Assoc. for Retarded Children	Bristol Cheshire Waterbury Winsted
6.	Connecticut Heart Association	Torrington Waterbury
7.	Conn. Society for Crippled Children & Adults (Waterbury Area Rehabilitation Center)	Waterbury
8.	Connecticut TB & Health Association	Waterbury
9.	Muscular Dystrophy Association	Waterbury Area Rehab. Center
10.	National Foundation for Diseases of the Central Nervous System	Torrington Waterbury

	Public Agencies	
1.	Veterans Administration Office	Waterbury
2.	State Department of Education Division of Vocational Rehabilitation	Waterbury (District Office) Local Offices: Bristol Torrington (2)
3.	State Department of Labor State Employment Service	Local Offices: Bristol Torrington Waterbury
4.	State Department of Health Crippled Childrens Section	One-per-month Clinics Charlotte Hungerford Hospital Torrington
5.	State Department of Health Office of TB Control	Out-Patient Services--Torrington Waterbury
6.	State Department of Mental Health Alcoholism Clinic	Waterbury
7.	Office of Economic Opportunity - Affiliated Agencies: New Opportunities for Waterbury Inc.	Waterbury
	Branch of New Opportunities for Waterbury, Inc.	Bristol

---

[11] Data Sources: Directory of Rehabilitation Resources in Conn., Ed. R.W. Bain State DVR, Hartford, Connecticut, 1966; Cooperative Area Manpower Planning System Report, Fiscal Year 1969, State of Connecticut

WATERBURY REGIONAL COMMITTE

STATEWIDE PLANNING PROJECT FOR
VOCATIONAL REHABILITATION SERVICES

July 1, 1968

Wesley C. Westman, Ph.D., Project Director
Statewide Planning Project for Vocational Rehabilitation Services
600 Asylum Avenue
Hartford, Connecticut 06105

Dear Dr. Westman:

We are forwarding herewith copies of the following:

1. Reports of Sub-Committees on:
    a. Interagency Cooperation
    b. Incidence of Disabilities
    c. Job Market and Manpower
    d. Vocational Training
2. Minutes of Meeting of June 20, 1968 (final).
3. Letter of Transmittal (This Document).

It is the intention of the Waterbury Regional Committee that these documents in their entirety shall comprise the final report to the Statewide Planning Project for Vocational Rehabilitation Services. The sub-committee reports shall provide background information bearing on the recommendations and suggestions which are listed in outline form herewith:

1. Establishment of network of regional information and referral service centers, funded by the State but organized and operated locally, with functions including coordination of services related to vocational rehabilitation.

2. A new study of planning areas throughout the State with a goal of establishing congruent lines of geographic demarcation.

3. Formation of a network of regional planning councils (to include all planning groups) with presently established planning groups in all fields to serve as functional sub-committees thereof.

4. Strengthening of all DVR district offices for emphasis on greater involvement in local school department activities in re dropouts and crisis points, prevention and intervention.

5. Re-evaluation of all vocational rehabilitation training programs with incentives offered to direct service agencies to stimulate development of new methods and new areas of training. Ongoing review of fees.

6. Establishment of conferences and seminars for DVR counselors and direct service agencies to insure emphasis on the client-

oriented viewpoint. In addition, development of greater knowledge of and closer relationships by DVR counselors with local business and industry to cultivate better and more job training and placement opportunities.

7. Development of standards for workshops, rehabilitation centers and others providing evaluation and other vocational services should be an on-going function of DVR.

8. Provision of funds by DVR is a necessity to allow more flexibility for transportation of the handicapped from less accessible areas or for maintenance of the handicapped near important centers of service when transportation might not be possible.

The Face Sheets on each Sub-Committee report will cover many of these same recommendations and, in some cases, reference will be made to the body of the report itself to indicate that it consists principally of listed suggestions and recommendations.

The Waterbury Regional Committee requests acknowledgement of this material and would appreciate being kept up to date on developments.

Respectfully Submitted,
WATERBURY REGIONAL COMMITTEE

Lester Greene, Chairman

WATERBURY REGIONAL COMMITTEE

STATEWIDE PLANNING PROJECT FOR VOCATIONAL REHABILITATION SERVICES

INTERAGENCY COOPERATION SUBCOMMITTEE REPORT

The first meeting of the Interagency Cooperation Subcommittee was held on March 5, at the Mental Health Association Office in Torrington. Mrs. Connie Prout presided.

At this meeting the five questions posed by the Task Force were discussed in some detail and answers and recommendations were made. It was felt that Torrington had a rather good situation in that they have a Committee on Community Resources, made up of the directors and staff of the community service facilities. It meets monthly and has just prepared a booklet on the resources of Northwestern Connecticut. This booklet is about to come out from the printer at this time. The general feeling of this particular meeting of the Subcommittee was that the cooperative agreements and day to day cooperation in general were excellent but that there was a need for better feedback and more written referrals. Problem in the northwest area of course, as noted, was transportation, and getting people to needed services. One of the questions which was raised was the possible feeling that agencies in Torrington and those in the Waterbury area tended to feel rather separate. However, those who work regularly with each other from these areas did not experience this feeling. The written minutes of this meeting are appended to this report.

The second meeting of the Interagency Cooperation Subcommittee was held on March 18, at the Torrington Public School Administration Building and Mr. Urich presided.

As a result of the first section of the meeting which was chaired by Mr. Mund, rough form of an interagency referral and reply form was designed. This form has now been refined and a copy of it is attached. This is currently being utilized on an experimental basis in Torrington and it is anticipated that a revised form of this referral sheet will be utilized by all agencies in the greater Torrington area in due time. Written copies of the minutes of this meeting are also appended.

Discussion:

A subsequent meeting was held on June 4, at the Mental Health Association Office between Mrs. Prout and Mr. Urich. At this time they reviewed the minutes of the previous meetings of the Subcommittee and discussed the general recommendations. It was felt that the problem as far Torrington is concerned is fairly well covered by the Community Resources Committee. However, because of the general make-up of the Committee we were not able to get good interaction with Waterbury area agencies for discussion regarding the Subcommittee's purpose. It is our feeling that the variety of services available in Waterbury undoubtedly require a different form of interagency cooperation than we have designed in the greater Torrington area. At the last Regional Committee Meeting in Waterbury, discussion was held regarding the possibility of a central referral source in Waterbury. Undoubtedly this has considerable merit and should be explored further. It so happened that our Committee was not able to get into the needs of Waterbury in this regard in any extensive way. We trust that this will be further evaluated by those people who are following through on the planning and reports of this Committee. Unfortunately, on our Committee those people **from** the Waterbury area were not able to attend. Mr. Allen Inger, representing Mr. Robert Grierson, was the only person from the Waterbury area who was able to participate. There may be an advantage to having a secondary subcommittee set up just for Waterbury agencies, if this is indicated. However, we are sure that the Planning Project representatives are well aware of the inter-relationships of the problems in the greater Waterbury area.

Recommendations:

We recommend that:

(1). Torrington continue to rely on the Community Resources Committee and their resource booklet which is about to be released from the printer.

(2). The Waterbury area give consideration to a central referral agency and evaluate the potential effectiveness of such a facility.

(3). Continuing efforts be made to insure the interagency cooperation between Waterbury and Toorington.

(4). The interagency referral and reply form as submitted by this Committee be considered for revision and utilization by the entire Waterbury and Torrington area.

INTERAGENCY REFERRAL AND REPLY FORM

(To be submitted to duplicate. Copy to be returned to originating agency as soon as form can be completed)

Confirming Tel. call ________

NAME: ________ Social Security No. ________

ADDRESS: ________ Tel. No. ________

AGE: ____ SEX: ____ MARITAL STATUS: ____ NO. OF DEPENDENTS: ____ RELIGION: ____

EDUCATION: (Grade Completed) ____ OCCUPATION: ________

DISABILITY: ________

REFERRED BY: ________ Address: ________ Tel. No. ________

ALREADY SEEN BY: ( )DVR ( )SSA ( ) WELFARE ( )VNA ( )OTHER ________ (List)

FAMILY SVC. ________ HEALTH ________ EMP.OFFICE ________

ENCLOSED:

AVAILABLE FROM FOLLOWING AGENCY WITH SIGNED RELEASE:

____	Social History	________
____	Medical Records	________
____	Psychological Reports	________
____	Psychiatric Reports	________
____	School Records	________
____	Other Information (List)	________

OTHER COMMENTS: ________

____
SIGNED

REPORT OF ACTION TAKEN

ACCEPTED FOR SERVICE: ________ INDIVIDUAL WOULD NOT COOPERATE: ________

REFERRED TO MORE APPROPRIATE AGENCY: (List Name) ________

WILL BE SEEN AT LATER DATE: (Indicate when) ________

CANNOT BE OF SERVICE - PLEASE REFER ELSEWHERE ________

OTHER ACTION: ________

REPORT WILL BE FORWARDED AFTER: ( )30 ( )60 ( )90 days
REQUEST CONFERENCE WITHIN: ( )30 ( )60 ( )90 days
NOT REPLY REQUESTED ________

____
SIGNED

FINAL REPORT OF THE SUB-COMMITTEE ON THE INCIDENCE OF DISABILITIES

A. Findings

Findings of this committee, based on existing statistics available from the Division of Vocational Rehabilitation indicated that the rate of reported, referred and disabled clients represents only a small portion of the total potential clientele.

Special attention for services available to the mentally retarded show that case finding in general is good for this group but the delivery of service lags for lack of professionals and caretakers alike.

Most epileptics appear to be employed. Unknown epileptics are thought to be few in number. The alcoholic is most prevalent and least reported of the groups studied. For instance, the November, 1967 statewide Division of Vocational Rehabilitation caseload, all diagnosed, was 4,249. The alcoholics were presumably included in the 29% or 1,232 "other mental disorders". The prevalence of alcoholics in 1965 in the 40-town area covered by this report is estimated variously at 11,455 to 13,257. It is surmised that the discrepancies which appear to exist between the prevalence of disability in the population and the number reaching the Division of Vocational Rehabilitation exist because:

a. Certain disabilities are diagnosed more readily, earlier, and with less embarrassment than others.

b. Certain disabilities are more readily accepted by the Rehabilitation professional than others because of such varying factors as favorable prognosis, emotional appeal or readiness of industry to cooperate in rehabilitation.

c. Certain disabilities require special coordinating techniques in the delivery of services involving special management by both the referral and the rehabilitation agency.

B. Recommendations

1. The creating of an inter-agency referral service should be considered for the greater Waterbury area. It is felt that such a referral service should be keenly aware of the needs of the clientele, able to assist individuals to find help, but also engage in some over-all planning; such as might be needed for high school drop-outs, possibly urging school boards to hire additional school social workers and develop a program of orientation for the medical profession regarding the availability of vocational rehabilitation services.

2. There should be further experimentation on the sharing of staff of all existing agencies. It is suggested that referrals would be carried through with greater consistency and the quality of services would be improved, if school and psychiatric social workers would spend some time at the offices of the Division of Vocational Rehabilitation. Vice versa, the presence of counsellors of the Division of

Vocational Rehabilitation at State hospitals, psychiatric clinics and welfare departments may lead to more thorough case finding and better cooperation of all helping agencies.

3. Involvement of industry could be improved:

   a. By referral of the malfunctioning employee.

   b. By improvements in the area of out-patient psychiatric insurance coverage.

4. Connecticut's northwest area has special needs for "bridges" from institutional care back to community living in order to insure continuity of the rehabilitative process. Half-way houses for alcoholics, parolees, mentally ill and impulse-ridden young adults are badly needed.

5. There is a need for additional research, specifically:

   a. A continued study of the rates of incidence

   b. A further understanding of "drop-outs" from the Division of Vocational Rehabilitation Programs.

WATERBURY REGIONAL COMMITTEE

STATEWIDE PLANNING PROJECT FOR VOCATIONAL REHABILITATION SERVICES

Vocational Training Subcommittee

The committee felt that Vocational Training included all vocationally oriented services which are component parts of the "total" vocational rehabilitation process. It was agreed to limit the committee's scope to those disabled persons who are not able to be handled through the normal vocational services resource channels. It was felt that the D.V.R. Counselor must determine at what vocational training level each individual client should start and then follow the client along the road to his permanent employment.

It was felt that vocational training should at least include the following resources for clients with all types and degrees of problems.

1) Vocational Evaluation at Rehabilitation Centers, Workshops, etc.

2) Pre-Employment Training and/or Work Adjustment at Rehabilitation Centers, Workshops, etc.

3) Individual specific skill training
   A) Public and Vocational Schools
   B) On the job
   C) Specialized (normal) training programs

4) Higher education - with subsequent training on the job

5) Long term sheltered employment

6) High school Work-Study Programs with Rehabilitation Centers and Workshops

Suggestions and Recommendations:

1) That standards for Worshops, Rehabilitation Centers, etc., providing evaluation and other vocational services should be established by D.V.R.

2) That the rural geography and population of the district limits the feasibility of establishing comprehensive rehabilitation facilities in areas other than Waterbury.

3) That established Rehabilitation Centers, Workshops, etc., should be further encouraged to provide transportation to clients in rural areas whenever and wherever possible.

4) That clients unable to reach a resource because of travel time and/or transportation problems should be provided maintenance funds in order to live near the resource.

5) That there is need for private transportation arrangements from Bristol to Waterbury resources because there is no public transportation.

6) That there is little knowledge of or use of Individual Specific Skill Training resources in the area by the D.V.R. counselors.

7) That there is no long term sheltered employment facility in Waterbury and that this service should be explored at the Easter Seal Rehabilitation Center. That annual operating funds should be made available for servicing long term severely disabled workers.

8) That counselors should be assigned to all secondary school systems to provide counseling, vocational guidance, etc.

9) That Work-Study Programs be established where feasible between school systems and Rehabilitation Centers, Workshops, etc.

10) That the D.V.R. counselors must develop detailed knowledge and closer relationships with the local employers in order to cultivate on the job training and placement opportunities.

11) That all existing vocational training resources be given the opportunity to expand, develop and service larger geographic areas and thus service more people before additional resources are considered.

12) That Rehabilitation Centers should consider developing specific skill training programs for persons who cannot take advantage of existing programs.

13) That counseling and vocational training services should not necessarily stop when a client is placed on a job.

WATERBURY REGIONAL COMMITTEE

STATEWIDE PLANNING PROJECT FOR
VOCATIONAL REHABILITATION SERVICES

FINAL REPORT - SUB-COMMITTEE: JOBMARKET AND MANPOWER

Current patterns of employment for handicapped people cover a broad spectrum of job categories throughout all types of business and industry. This is true in spite of the fact that there are innumerable job categories which require perfect health at the outset. Most workers acquire some disabilities along the way for which they are unable to adjust in order to maintain efficiency on the job. Many of these disabilities are not known to their employers. This pattern is generally applicable to the State and to the Nation. Job applicants who are dealing with recently occurring disabilities find that most of them can return to their former employment under conditions which may require only minor adjustments. Those that are severely handicapped find that they can enter new fields of employment after a thorough medical and psychological evaluation, professional counseling and sufficient training to enable them to develop new skills.

Major changes in occupational patterns will take place at an ever increasing pace throughout the State. More and more manufacturing operations and processes will be shifted from the manual-skill type of job to a blue collar, push-button computer and tape operation which should open opportunities for handicapped people if suitable training is provided.

These changes will come at various times and at a varied pace. The foundry mill operations in the State are now almost completely automated. In the Waterbury area, for example, all major companies involved in either rolling mill operations or iron foundires are already automated or about to become so. Manufacturers of machinery, tools, dies, and molds will become computerized in the near future. The duties to toolmakers, machinists, machine operators and inspectors will be changed according to this pattern. Banking and other financial institutions, insurance companies, marketing specialists, wholesale and retail trades will continue to make greater and greater use of automation and computerization and tape machine technology. Many scientific and mathematical techniques will depend on greater use of computers and other automated equipment to perform relatively routine computations.

All public and private agencies involved in the rehabilitation and training or retraining of the handicapped should be kept fully informed of changes brought about by automation and other technological changes. When these changes are about to occur, the information should be disseminated through standardized methods so that all concerned can plan to make adjustments to meet the changes.

A committee consisting of representatives of the various agencies should do early planning through programs such as WINS (Work Incentive), MDTA, Cooperative Agency Manpower Planning System and other community programs designed to help the handicapped and supply manpower needs.

WATERBURY REGIONAL COMMITTEE

STATEWIDE PLANNING PROJECT FOR

VOCATIONAL REHABILITATION SERVICES

The final meeting of the Waterbury Regional Committee was held June 20, 1968, with Lester Greene presiding.

After Mr. Greene announced the disposition of the final reports, Mr. Jernigan reported that the CAMPS Coordinating Proposal, recommending the establishment of a sheltered workshop for the region, with supporting recommendations of DVR, the Rehabilitation Center and the Alcoholism Rehabilitation Sub-Committee of the Mental Health Council, had been sent to Hartford.

Mr. Greene stated that most of the reports received indicated a common need: information and referral services. In support of this statement, Mr. Greene showed that this has been a long-standing need in this region by referring to the final report of the Rehabilitation Services Study Committee of the United Council and Fund, in which is stated: "This Committee has been in existence for nearly three years" ... "The number one problem in the field of rehabilitation is reluctance on the part of the agencies concerned, to develop the concept that it is people, not conditions, which must be served; that resources in the community should be pooled to this end. The number two problem is that of poor communications resulting in unmet needs, poor referrals, overstaffing and shortage of qualified personnel, unawareness of State and Federal financial help and consultation available."

Information gathered by an Information and Referral Service should more clearly indicate unmet needs and provide a base for continued planning and implementation. Acting as a clearing house, such a service might improve communications between agencies, including "feedback" on referrals, and better pooling and coordination of services might result. I & R would, in addition, provide better information for the public as to services available, and might help discover some of the "hidden disabled".

In previous meetings, this group had discussed the possibility of calling the Inter-Agency Cooperation Sub-Committee the Inter-Agency Cooperation and Coordination Committee. Mr. Greene's emphasis was on the fact that an I & R service might serve to stimulate the coordination of activities of all agencies. Mr. Wise offered his understanding that the DVR counselor and the DVR office is responsible for coordination of the services which it uses. Here, the emphasis is on client service, and this should continue to be a major focal point of this effort.

Mr. Jernigan pointed out, in support, that, in essence, this kind of role is actually that of the DVR counselor. Mr. Greene suggested that perhaps a strong coordinating service within DVR might be the answer as to where such a service could be located in the community -- a special Social Service section to be established and strengthened in the local or district DVR offices.

Mr. Wotton was asked to speak, reporting on the proposal for an Information and Referral Service recently drawn up under the auspices of the Greater Waterbury United Community Fund.

Mr. Urich indicated the great difference between the needs of Waterbury and Torrington and stated that the work of the Committee on Community Services is sufficient in his area, to which Mr. Wotton replied that interregional and statewide information and communication is vital. A well-staffed I & R service could be the focal point of such coordinating effort, as well as a means for providing better public education and information.

The next topic discussed was the lack of uniformity among planning regions, which necessitates going to various places for different services. The establishment of congruent regions among agencies would prevent much of the confusion in statistical material and study, as well as in grouping and development of services.

Mr. Hasler, representing the sub-committee on disability, agreed with the need for I & R, further developing the need for greater availability through coordination of services and therapy. The gaps existing between the number of potentially referrable and those receiving services must be overcome. Consideration of the needs of clients might better be achieved with shared staffing among the agencies, and increased participation in one another's programs.

Passing to another phase of the committee's study, Mr. Hasler urged more attention to crisis points and preventive intervention, particularly in dealing with dropouts. The Committee members agreed to recommend a high degree of collaboration between DVR and the Waterbury school system. However, Mr. Jernigan referred to the DVR age limits which would limit these services to fourteen year olds and older young people. Mr. Greene expressed the opinion that, since DVR was part of the State Department of Education, to which local school boards are closely related, the State might be in a better position to assist in the resolution of these problems, either by directives or firm recommendations.

Since no member of the sub-committee on Manpower and Job Training was present, Mr. Greene summarized its report which concerns itself principally with the increase of automation in industry and the consideration of needs for retraining the handicapped in other than manual skills. One suggestion is programs for training in computer and data processing techniques. The report further emphasizes the need for information on trends in in industry and the necessity for those agencies concerned with retraining to have up-to-date information. This lends support to the need for an I & R service. Mr. Greene added that consideration should be given to training in services. Mr. Wotton remarked that employment increases in recent years have been in service-type business, not in industry. As a result, the development of new types of training programs would seem to be indicated.

Mr. Greene then presented to the Committee the question of its future status: should it continue to meet? Mr. Wotton offered one criticism of the group as it exists; namely, that it is lacking in having only professionals but no consumers, laymen, or other members of the community at large. Mr. Greene pointed out that, as originally established, this regional committee included members of such categories, but that many had never attended meetings, some had attended but lost interest, or had too many other commitments. The question then was where such lay members might be recruited. Mr. Greene reminded the Committee that its basic work is completed, for the present. It will not be necessary to meet again until the fall, perhaps to review and consider the final report of the Statewide Planning Project. It was suggested that, at that time, a decision might be reached as to a future course for the committee. Mr. Wotton suggested that each member of the present group attempt to bring with him an interested layman from the group represented by the member.

As to the future function of this Committee, Mr. Jernigan suggested that there might be some manner of participation in legislative action. Mr. Hasler suggested that the Committee might review applications such as the Mental Health Councils are empowered to do: and finally, it was suggested that the final report of the Committee submitted to the Statewide Planning Project include a recommendation that this Committee continue as a planning group. Mr. Stanley said that the Committee might concern itself with the two major needs pointed up by the reports; namely, I & R and client-oriented coordination. Mr. Greene repeated that these would require professional staffing, and Mr. Wottom added that this Committee could not assume those functions. Mr. Greene did say that the Committee might assume a "policing function" in relation to the final recommendations of the Statewide Planning Project, particularly with recommendations affecting the local situation.

In conclusion, Mr. Wottom suggested and Mr. Greene agreed that the eventual need and result would be an overall Regional Planning Council, and that this group might then become the Vocational Rehabilitation Services Committee of such an overall council.

(Digest of Minutes)

WATERBURY REGIONAL COMMITTEE

CHAIRMAN

LESTER GREENE
EXECUTIVE DIRECTOR
CEREBRAL PALSY ASSOCIATION OF WATERBURY

Miss Nancy Ballentive, Director
Social Service Department
Bristol Hospital

Joseph Barrante
Superintendant of Walfare
Torrington

C. Arthur DuBois
Waterbury

George Rehrs, Business Manager
Southern New England Telephone
Company

Raymond Fitzpatrick, Executive
Director
Waterbury Association for
Retarded Children

Mrs. Lewella Frances
Social Service Department

Robert Grierson, Employment
Counselor, Connecticut State
Employment Service

Werner Hasler, Social Worker
Psychiatric Clinic, Waterbury
Hospital

Allen Inger
Connecticut State Employment
Service

John Jernigan, District
Supervisor
Division of Vocational
Rehabilitation, Waterbury

Edwin Keyes
Division of Vocational Rehab.

Kenneth Knott, Labor Representative
United Council & Fund of
Greater Waterbury

Francis Lago
Waterbury Rehabilitation Center

Guido LaGrotta, Representative,
Warren House of Representatives,
Connecticut

Miss Mary Martin, Supervisor
Connecticut State Welfare Department

John Moore, Jr., Director
Youth Opportunity Center
Connecticut State Employment Service

E.R. Meyer, Assistant Director
Warren F. Kaynor Regional
Technical School

Mrs. Harold Prout, Executive Secretary
Mental Association of Northwestern
Connecticut, Torrington

Joseph C. Reytkewich, Mayor
Borough of Naugatuck

John Roberts, Director
Pearl Street Neighborhood House

Anthony Russo, Torrington

Alvin Singleton, Manpower Administrator
New Opportunities for Waterbury, Inc.

Mrs. Wilbur Trask, Executive Secretary
Mental Health Association of
Central Naugatuck Valley, Inc.

James Tyrell, Adult Education Supervisor
Wilby High School, Waterbury

David Urich, Director
Northwestern Regional Center, Torrington

Donald Wise, Executive Director
Waterbury Area Rehabilitation Center

Peter Wotten
Mental Health Planning Council,
Central Naugatuck

REPORTS OF
TECHNICAL ADVISORY COMMITTEES

TECHNICAL ADVISORY COMMITTEE
ON
INTER-AGENCY COOPERATION

The Technical Advisory Committee on Inter-Agency Cooperation has met on six occasions since March 27, 1968. Our assignment was to examine the existing structure of state government as it relates to public and private agency cooperation in the delivery of services to the disabled citizens of Connecticut.

In order to cover our assignment in the brief time allotted, each member took the responsibility for reviewing and reporting on one of the existing cooperative agreements or working relationships between DVR and related agencies and recommending methods for improving cooperation. The individual reports and recommendations as submitted by the individual members and discussed at the committee meetings are attached. These reports have been summarized and used as a basis for the committee's recommendations.

Although we felt that three of our recommendations (Inter-Agency Staff Training, Inter-Agency Agreements, and Increase in Staff Positions) have validity and would help improve services to the disabled in our State, they are not particularly original, representing recommendations which have been made on several other occasions following studies similar to this one. We were, in fact, less than pleased with our recommendations which were only getting at minor mechanics rather than hitting at the core of the problems in rehabilitation. Because of this, and the fact that we would not be eliminating the existing fragmentation of services to people in need of rehabilitation, the Committee was delighted with Mr. Sholom Bloom's report outlining a Statewide plan of cooperation and coordination of all rehabilitation services. At first, it appeared to us that we would be going beyond our assignment. However, as we discussed it further, the plan appeared to be so refreshing, exciting, and obviously necessary, that the Committee agreed to explore it further for our recommendation purposes.

A sub-committee (Dr. George Walker, Miss June Sokolov, and Mr. Sholom Bloom) was then assigned to develop further this broad concept of effective inter-agency cooperation brought about through a structure of coordinated State planning. It is with considerable appreciation of what this plan, if implemented, would do for the disabled in Connecticut that we are submitting it as our number one and major recommendation.

Lorraine R. Loiacono, Chairman
8/19/68

FINAL REPORT OF TECHNICAL ADVISORY COMMITTEE

MODEL AND PLAN OF ACTION FOR INTER-AGENCY COORDINATION AND DELIVERY OF SERVICES

I INTRODUCTION

It may be inquired why this Technical Advisory Committee has recommended a global approach to the problems of inter-agency cooperation and, consequently, has gone beyond the boundaries stipulated by the Division of Vocational Rehabilitation Survey Committee.

In our judgment, all piecemeal efforts at cooperation are foredoomed to failure (witness the current disordered and fragmented operation of service agencies) without the supporting structure of coordinated State planning. There was, accordingly, consensus on the part of the Technical Committee to direct its efforts toward effective coordination. To this end, a blueprint was developed which postulates involvement of the topmost level of State Government.

Conditional to the active cooperation of agencies and the dynamic delivery of services must be authority stemming from the Chief Executive's Office in the form of both moral commitment and an effective coordinative design.

It is further posited that coordination needs to be dynamic, flexible, and creative, and that it cannot, by definition, be applied only to single departments without looking to all sub-parts of State Government and the voluntary Health and Welfare agency structure.

In order to implement this thesis, it is suggested that a new divisional entity entitled "Governor's Coordinating Council" be established. This vehicle is intended to serve as the hub of a State system of coordination.

Another basic premise of the proposed plan would invite representation from every segment of government, of voluntary and private effort concerned with the planning and delivery of services.

The Technical Advisory Committee takes cognizance of Public Act 697 (1965 Legislature) which establishes a State Planning Council. This Council has the authority and jurisdiction to function as a Statewide Planning Agency and coordinator for other State agencies. However, the elements for insuring such coordination at all levels are not clearly apparent in the Act. With the goal and objective of providing a model for effective public and private agency coordination and delivery of services, the following supplementary design is offered.

II DESIGN

1. Governor's Coordinating Council

   This body is envisioned as the Governor's "braintrust," a "think-tank" group which would have as its major function the establishment of goals and priorities for State agencies (based on prior problem-analysis).

   Membership would consist of highly qualified specialists, scientists, lay members drawn from other Governor's Councils (i.e., State Planning Council) as well as from public life.
2. Inter-Agency Coordinating Council

   This Council is conceived as a changing cluster of agency personnel concerned with identifying and analyzing common or core problems. Examples of such problems might include transportation resources, information and referral, etc. This vehicle would permit focusing the attention and skills of concerned agency personnel on changing problems associated with the delivery of services.

3. Manpower - Training and Coordinating Council

   This Council would comprise the various elements concerned with recruitment and training of manpower. Its efforts would be directed toward worker-orientation and the development of technical courses emphasizing coordinative and consultation skills.

4. Federal-State Coordinating Council

   This body would consist of representatives from all agencies which receive federal funds. Its purpose would be to establish and expedite procedures for simplifying and acting in an advisory capacity to the coordinator of federal grants in the Department of Finance and Control.

5. Legislative Coordinating Council

   This Council would consist of representatives from all agencies concerned with the legislative process as well as appointed legislators. It would work to provide viable and needed legislation and would act as a clearing house for such efforts. (The existing Legislative Research Council might be utilized as the hub of this body.)

6. Research Coordinating Council

   This Council would comprise representatives of those agencies concerned with study and research activities. Its major focus would be directed toward developing a global approach to such research, establishing priorities, long-range research designs, etc. The emphasis is conceived to be on applied research directed toward improving creative programing.

7. Fiscal Coordinating Council

This Council would include representation from business and fiscal administrators of State agencies. Its primary goal would be effectively to translate dollars into the program and operational requirements of agencies.

8. Computer and Communications Center

What is envisioned here is the establishment of a State Center which would gather data, store it, and provide all operating agencies with substantive information. The Center would serve as a strong link between agencies with respect to input and output of objective data.

III METHODOLOGY

1. It is recommended that a Technical Advisory Group be established, using the task-force approach, to implement the Design.

   It is envisioned that practical exponents of the sciences might turn their efforts toward the inter-relationship of organizational behavior, systems analysis, urbanology, political science, public administration, and social welfare.

2. The creation of local and/or major regional information-and-referral specialists is conceived as part of the communications system linking the client-citizen with I. & R., and I. & R. with the Councils. This

would conceivably help to coordinate the direction and dissemination of information and minimize conflicting directives. The Computer and Communications Center would be related to such I. & R. specialists, providing them with current and accurate data for client consumption.

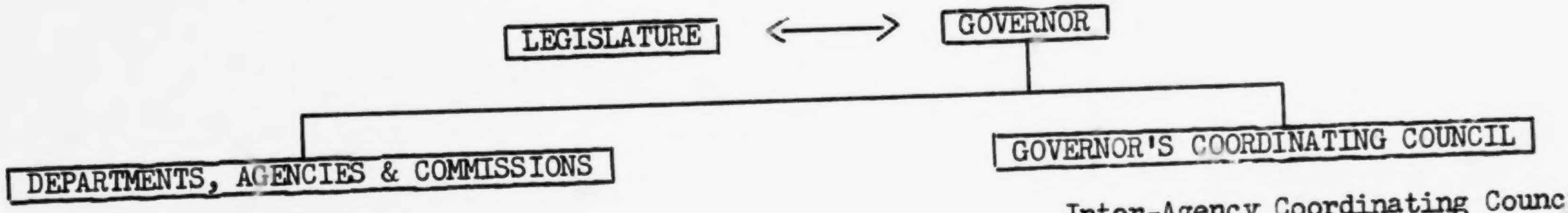
3. An underlying premise of the entire plan is the assurance of lay participation and the introduction of a cross-section of consumers and non-professionals on all Councils.
4. The basic assumption of the plan is that Social Welfare Agencies are charged with the provision of integrated, comprehensive services and continuing care to society's handicapped members.

IV DESCRIPTIVE CHART

See "Model for Effective Public and Private Agency Coordination and Delivery of Services".

MODEL FOR EFFECTIVE PUBLIC & PRIVATE AGENCY COORDINATION AND DELIVERY OF SERVICES

DIAGRAMATIC SCHEME


LEGISLATURE
GOVERNOR
DEPARTMENTS, AGENCIES & COMMISSIONS
GOVERNOR'S COORDINATING COUNCIL

DEPARTMENTS, AGENCIES & COMMISSIONS

Health
Welfare
Education
Mental Health
Community Affairs
Public Works
Labor
Corrections
Finance & Control
Etc., etc.

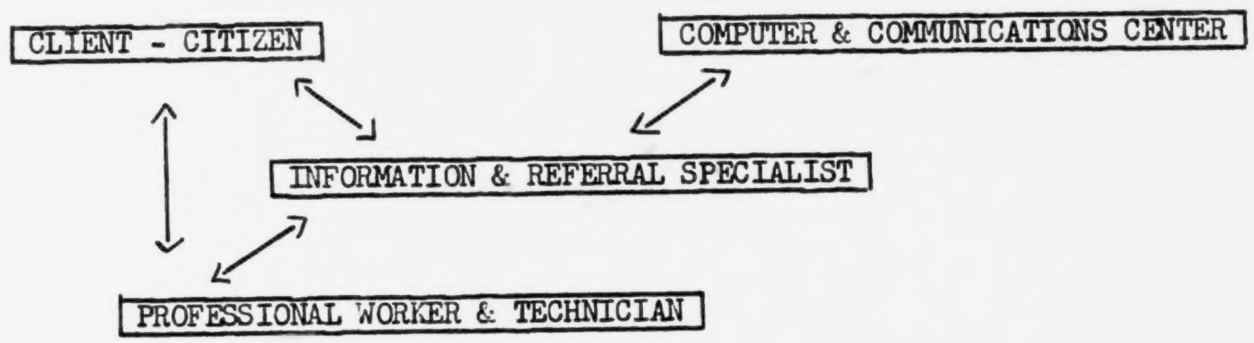
GOVERNOR'S COORDINATING COUNCIL

Inter-Agency Coordinating Council
Manpower - Training & Coordinating Council
  Executive training, worker orientation, Technical courses for staff, utilization of scientific knowledge, consultation skills laboratory, human relations skills laboratory
Federal-State Coordinating Council
Legislative Coordinating Council
Research Coordinating Council
Fiscal Coordinating Council
Computer and Communications Center

BASIC ELEMENTS

Computerization and Automation (data gathering, reporting, storage, retrieval)
Communication (teletyping, linkage, feed-back, feed forward)
Information and Referral Agent at Local/Regional Level
Technical Advisory Group (task force of scientists from State and local universities)
  organizational behavior, system analysis, urbanology, political science, public administration, social welfare

FLOW SYSTEM (TRI-PARTITE)


CLIENT - CITIZEN
COMPUTER & COMMUNICATIONS CENTER
INFORMATION & REFERRAL SPECIALIST
PROFESSIONAL WORKER & TECHNICIAN

Professional Workers and Technicians
Comprehensive Continuing Care
Citizen Participation - lay

INTER-AGENCY STAFF TRAINING PROGRAMS

There was agreement among committee members that a recommendation be made for inter-agency staff training programs. This was felt to be extremely important since the effectiveness of the staff member, in large measure, depends upon his knowledge, training, and techniques.

Such training programs familiarize the worker with services available from other sources. They also allow for a coordinated approach in providing services to clients. To be effective, these programs should be conducted on an ongoing or periodic basis.

The need for joint training and orientation programs between agency staff members was underscored in several of the reports submitted by committee members. The present system, in many instances, is casual and leaves the worker a trial and error method of learning about community resources and services.

The Committee recommends a structured plan of orientation and training between the workers of DVR and other agencies for the purpose of learning the scope and specifics of service provided by the cooperating agencies. A prior knowledge of existing resources saves time, not only from the point of view of the agency, but also in speeding up the rehabilitation process of the client.

The committee's recommendation does not spell out specific methods of implementing the inter-agency training programs. This is being left to the agencies concerned. One suggestion was made for the use of Training Coordination in the State Personnel Department as a resource in developing appropriate programs. Another suggestion was that special assignments of agency staff be made to carry out this function.

INTER-AGENCY AGREEMENTS

It is recommended that there be written agreements between DVR and other agencies. Although several agencies have working relationships and/or cooperative arrangements, it was the consensus of the committee that a written agreement has many advantages. One purpose of a written agreement would be to provide a joint statement of principles of cooperation so that the activities of each agency would be coordinated to provide the best possible service to disabled persons, thereby helping them to achieve the maximum degree of personal, social, and economic independence. The agreement should include a description of the services to be provided by the cooperation agencies, the method of inter-agency referral, the personnel to carry out the commitments of each agency, the procedure to be followed in information, and the stated interval of periodic review of the terms of the agreement, preferably on a quarterly basis and by appointed agency representatives or by an established committee.

However, a written agreement does not, of itself, assure cooperation, coordination, and delivery of services. Essential to the implementation of the terms of the agreement would be planned joint sessions whereby the workers would be oriented to the commitments of their agencies to provide service and also become aware of their responsibilities in delivering appropriate services to the client at the time he will benefit most from them.

The Committee wishes to call attention, especially, to the situation between DVR and The Workmen's Compensation Commission. An old, outmoded agreement exists which, in point of fact, has not been operative for a number of years. More fundamental is the fact that a major criterion for a soundly based working agreement between the agencies -- namely, an effective Workmen's Compensation Law -- is missing in the State of Connecticut. Therefore, in order to insure an effective relationship between DVR and W.C.C., legislative action to modernize our antiquated compensation law will be a prime requisite. Mobilization of citizen and governmental support is intrinsic to success.

INCREASE IN STAFF POSITIONS

The Committee recommends an increase in staff positions to meet the current and future demand for rehabilitation services. It is a well known fact, substantiated by the committee reports, that there has always been a shortage of counselor staff coverage in many areas of services provided by DVR. This shortage has become more acute with the passage of the Vocational Rehabilitation Amendments of 1965 and 1968. The amendments provide for enlarged areas of service and a change in the scope of eligibility for rehabilitation services. The eligible client is no longer limited to the physically handicapped, but now includes the person with a handicap due to mental disability and/or social and emotional maladjustments.

In order to assure delivery of services to all those who are eligible, there has to be adequate staff. The promotion of services which are uniformly available and improved in quality is not enough. There has to be sufficient staff to carry out the goals of rehabilitation.

The matching formula for State-Federal funds, which is now an 80-Federal to 20-State ratio, should facilitate the realization of increased staff, provided the State legislates additional funds for rehabilitation services.

SUMMARY OF REPORTS SUBMITTED BY MEMBERS OF TECHNICAL ADVISORY COMMITTEE ON INTER-AGENCY COOPERATION

The reports submitted by the committee members were studied and reviewed according to the following outline:

1. The agencies which have cooperative and/or working agreements with the Division of Vocational Rehabilitation
    a) whether they were written or otherwise
    b) whether they needed revision
2. The agencies which have no agreements
    a) whether an agreement was recommended
3. The quality and extent of daily inter-agency contact and cooperation at the local office level
4. The existence of an ongoing inter-agency staff training program or the need for one
5. Recommendations proposed in the various reports

I AGENCIES WHICH HAVE COOPERATIVE AND/OR WORKING AGREEMENTS WITH THE DIVISION OF VOCATIONAL REHABILITATION

A. Rehabilitation Centers and Workshops

1. There is an over-all written agreement between the Division of Vocational Rehabilitation and the Connecticut Society for Crippled Children and Adults which establishes work relationships for pre-vocational evaluation provided to the Division of Vocational Rehabilitation by facilities affiliated with the Connecticut Society for Crippled Children and Adults.
2. There are written agreements between the Division of Vocational Rehabilitation and specific centers such as

The Hartford Rehabilitation Center, Stamford Rehabilitation Center, the Sheltered Workshop of Bridgeport.

3. None of the agreements is less than ten years old and There is no provision for periodic review.

4. There was a recommendation for periodic revision to reflect the change in rehabilitation techniques, or legislative changes. An established committee should be responsible for periodic review of agreements.

B. The State Welfare Department

1. The Department has had a written agreement since November 1954. In November 1965, a review was made and the principles of cooperation between two agencies were restated, with a revision of a referral form. Further revision to conform with the 1967 Social Security Amendments is now in process. However, a written agreement does not, of itself, assure cooperation and coordination and delivery of services.

2. What is needed to assure delivery of services is inter-agency staff training and orientation on a regular and continuing basis, with an inter-agency committee to review the agreement on a regular basis.

C. Connecticut State Employment Service

1. The unit has had a long-standing written agreement which is currently being strengthened by revision.

2. Cooperation is encouraged in initial training and in

formal liaisons between the two agencies, specified personnel being responsible for their function.

D. Workmen's Compensation

1. Although there is a written agreement, it is extremely old, non-operative, and, obviously, in need of revision.
2. The existing statutes contribute to major problems because of the outdated and outmoded concepts of rehabilitation.
3. Recommendation was made for legislative action to modernize an antiquated compensation law and to revise the agreement, providing equitable services to injured workers.

E. State Department of Health - Office of Mental Retardation

1. There is no formal written agreement. However, there is an informal cooperative working relationship which involves assignment of rehabilitation counselors to the various facilties.
2. There was a recommendation for a formal written agreement with provision for joint program planning and periodic review at stated intervals by specified persons. An inter-agency committee was also recommended to coordinate efforts of two agencies.

F. State Department of Education - Bureau of Pupil Personnel and Special Education Services

1. There are cooperative programs with the Division of

Vocational Rehabilitation which spell out specific responsibilities of each agency.

2. A statement was included that in order to "facilitate the development and operation of the proposed program, the Bureau and the Division of Vocational Rehabilitation and the independent school systems will execute a written agreement". There are several of these written agreements currently in operation.

G. State Department of Mental Health

1. There are various working arrangements, on an individual basis, with each mental hospital and its facilities.

2. There was reference to a suggestion that a statement of agreement formalizing the various arrangements in local hospitals would be helpful.

II AGENCIES WHICH HAVE NO AGREEMENTS, AND WHETHER AGREEMENTS WERE RECOMMENDED

A. The Commission on Services for the Elderly

There was a recommendation for a "sub-commission level liaison."

B. The Connecticut State Jails

1. A program project was initiated two years ago in two local jails. The evaluation noted that services reached only a small number, and RECOMMENDATION WAS MADE FOR

a) extension of services to all jails
b) increased rehabilitation services and personnel
c) increased staff services from Division of Vocational Rehabilitation

C. Office of Economic Opportunity

1. The programs sponsored by the Office of Economic Opportunity are concerned with the potentialities of the individual and with his need for financial assistance, rather than with his physical or mental status. Therefore, none of the programs is specifically geared to the handicapped, with the exception of the Foster Grandparents program, where elderly persons are working with the mentally retarded child. There was no indication in the report of recommendation for an agreement, or for special programs for the handicapped.

III THE QUALITY AND EXTENT OF DAILY INTER-AGENCY CONTACT AND COOPERATION

Because of the programs and relationships, agencies such as the Commission for the Elderly, the Jail Administration, and the Department of Community Affairs did not have daily contact.

With other agencies, such as Welfare, the Office of Mental Retardation, State Department of Mental Health, the quality and extent depended upon the degree of counselor coverage in the area, and the knowledge and skill of the individual worker and counselor. With one agency, the Connecticut Employment Service, the quality was considered good and when it became weak, administrative and supervisory efforts were made to strengthen it.

IV RECOMMENDATIONS

(At this time, recommendations will be presented in outline form only.)

1. Model and Plan of Action for Inter-Agency Coordination and Delivery of Services

2. Provision for Inter-Agency Staff Training Programs
   These programs should be on an ongoing or periodic basis.

3. Agreements Between the Division of Vocational Rehabilitation and Other Agencies
   These should be in written form and should clearly state responsibilities of each agency. A staff member of each agency should be designated to carry out this function.
   Periodic Review should be done quarterly by a designated committee representing the agencies involved in the agreement.

4. Increase in Staff Positions
   This increase is necessary in order to meet the demand for increased rehabilitation services.

AGREEMENT
FOR A COOPERATIVE PROGRAM
OF
VOCATIONAL REHABILITATION AND SPECIAL EDUCATION
IN PUBLIC SCHOOL SYSTEM(S)

WHEREAS, public school special educational programs for handicapped children and vocational rehabilitation in Connecticut basically have the same ultimate objectives; namely, to assist youth handicapped by disability to make the best social, psychological, and vocational adjustment of which they are capable, and

WHEREAS, special education and vocational rehabilitation programs would be enhanced and improved in large measure if these two programs blended at the proper time before "formal education" is ended,

The Bureau of Pupil Personnel and Special Educational Services of the Connecticut State Department of Education, the Board of Education of the Town of Hartford, Connecticut, and the Division of Vocational Rehabilitation of the Connecticut State Department of Education enter into this agreement to cooperate in providing vocational rehabilitation services on an organized and systematic basis at the secondary school level. These services would be provided to youth handicapped by physical, intellectual, or emotional disabilities and complement the special education program already in existence in said public school system.

GENERAL

1. The division of Vocational Rehabilitation and the Bureau of Pupil Personnel and Special Educational Services of the Connecticut State Department of Education will jointly be responsible to provide the

original and the continued orientation of the relevant local school staffs as to the purpose, policies, and operation of such vocational rehabilitation services.

2. Referral of students to the school vocational rehabilitation counselor shall be made only through that school staff member appointed by the superintendent of schools for that purpose. The school vocational rehabilitation counselor shall not accept students as clients except those so referred who meet the eligibility criteria of the Division of Vocational Rehabilitation. The reason for this policy is to place the responsibility of referrals to one person for administrative control; however, it does not negate or discourage the unit staff members to make referrals through the unit staff conferences.

3. The school vocational rehabilitation counselor and secretary are employees of the Division of Vocational Rehabilitation of the Connecticut State Department of Education and are under supervision of same; the local public school system has no direct authority over said vocational rehabilitation counselor and the vocational rehabilitation counselor has no authority over any local school staff. However, he will respect the administrative regulations and operating procedures of the school system.

4. The determination as to eligibility of students referred to the school vocational rehabilitation counselor for vocational rehabilitation services shall be the decision of the vocational rehabilitation counselor.

5. In general, all handicapped students who will have attained the minimum age of employment established by state statutes by the time

the rehabilitation services are complete, shall be considered potentially eligible for vocational rehabilitation services. This will warrant the setting up of a rehabilitation program for them.

6. The selection of personnel for, assignment of personnel to, separation of personnel from the rehabilitation unit will be the primary responsibility of the superintendent of schools in the respective school system(s). The selection and the assignment of the vocational rehabilitation counselor for the rehabilitation unit, which is done by the Division of Vocational Rehabilitation, must meet the approval of the Superintendent of Schools. However, the foregoing is subject to the final spproval of the Division of Vocational Rehabilitation.

7. Direct supervision by the Division of Vocational Rehabilitation in this requirement refers to establishing eligibility of clients, making rehabilitation plan for clients, and authorizing expenditures for clients receiving services from the vocational rehabilitation unit. It is to be understood that, insofar as the operations of the program involve cooperation with the school system(s) personnel, the rehabilitation unit will operate under the administrative control of the school system(s), although only the Division of Vocational Rehabilitation has direct responsibility for the authorization of expenditures.

8. With regard to third-party funding, the school system(s) (with the assistance of consultative staff from the Bureau of Community and Institutional Services, DVR, and rhe Bureau of Pupil Personnel, Division of Instructional Services) must make application to the

DVR for Federal matching funds by completing Form A and complying with instructions. The school system must also complete Form B for reporting of financial expenditures, 6 months after the program has begun. The school system(s) must also report monthly, the amount of funds expended, through services in kind, which are certified for matching to the State Agency.

9. Any changes of salary, personnel, space, or facilities shall require participation by all parties in the agreement and through proper processing.

10. The amount of funds obtained by third-party financing will be used for the cooperative school rehabilitation program in the State of Connecticut. In the event that a greater amount of funds is earned than is needed by the copperative school program, the balance can be used by the Division of Vocational Rehabilitation to develop other programs.

The Bureau of Pupil Personnel and Special Educational Services of the Connecticut State Department of Education agrees to:

1. Approve the provision of vocational rehabilitation services to the public secondary schools of the Town of Hartford, Connecticut.
2. Provide consultation as may be needed to the school principal or other designated school system official in coordinating the existing special education program in the school system with the program of rehabilitation services; to be available for consultative services concerning handicapped students requiring vocational rehabilitation services.
3. Assume other responsibilities and functions that may be necessary and mutually agreed upon by the parties hereto.

The Board of Education of the Town of Hartford, Connecticut agrees to:

1. Provide quarters to house the vocational rehabilitation counselor and his secretary, including private space for interviewing and counseling student-clients, telephone coverage, maintenance, utilities, supplies, and equipment.
2. Provide the vocational rehabilitation counselor access to all school records relevant and necessary for the provision of effective vocational rehabilitation servises to student-clients.
3. Maintain appropriate accounts and records and make reports as required.
4. Provide for coordination of existing special education programs within the school system with the vocational rehabilitation program.
5. Provide, to the extent available, those services necessary for the evaluation and follow-up of students referred to the vocational rehabilitation counselor, such as psychological evaluations, social case work reports, speech and hearing services, transportation, etc.
6. Assume other responsibilities and functions in relation to the rehabilitation services that may be necessary and mutually agreed upon by the parties hereto.

The Division of Vocational Rehabilitation of the Connecticut State Department of Education agrees to:

1. Assign and pay the vocational rehabilitation counselor(s) and a secretary to the rehabilitation unit in the school(s). These staff members will be full time.
2. Develop budget and program of the rehabilitation services.

3. Coordinate the existing state vocational rehabilitation program with the program of rehabilitation services in the school system(s).
4. Supervise operational aspects of the rehabilitation service.
5. Authorize all expencitures for vocational rehabilitation services provided by the Division of Vocational Rehabilitation counselor.
6. Furnish guidelines to the local public schools for the identification of students properly referrable for vocational rehabilitation services.
7. Keep individual case records for each individual receiving services of the school rehabilitation counselor. These records will be kept at the rehabilitation unit.
8. Assume other responsibilities and functions that may be necessary and mutually agreed upon by the parties hereto.

This agreement shall become effective upon its signing by duly authorized representatives of the parties hereto.

This agreement may be terminated: (1) by any party on sixty (60) days written notice and as mutually agreed upon by the parties hereto, (2) if one party does not meet its commitments in the agreement.

General Agreement:

In line with the requirements of Assurance of Compliance with the Department of Health, Education, and Welfare regulation under Title VI of the Civil Rights Act of 1964, the parties making the agreement agree that they will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all the requirements imposed by or pursuant to the Regulation of the Department of Health, Education and Welfare (45 CFR Part 80) issued pursuant to that Title, to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United

States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicants receive Federal financial assistance from the Department; and hereby gives assurance that it will immediately take any measures necessary to effectuate this agreement.

R.W. Stoughton, Bureau Chief
For the Bureau of Pupil Personnel and Special Education Services, Connecticut State Department of Education
3/18/68
Date

James S. Peters II
Director, Division of Vocational Rehabilitation
Connecticut State Department of Education
3/6/68
Date

Ellis L. Tooker
For the local Board of Education
3/13/68
Date

PLAN FOR REHABILITATION OF THE HANDICAPPED STUDENT
THROUGH COOPERATIVE PROGRAM BETWEEN
THE DIVISION OF VOCATIONAL REHABILITATION
AND
THE BUREAU OF PUPIL PERSONNEL AND SPECIAL EDUCATIONAL SERVICES
OF THE STATE DEPARTMENT OF EDUCATION AND SCHOOL SYSTEMS
IN THE STATE OF CONNECTICUT

Background Information

The State Department of Education is charged by law with the responsibility for a State program of education and vocational rehabilitation of handicapped children, youth, and adults, from the time they enter school until they are placed on the job. The Bureau of Pupil Personnel and Special Educational Services works with local school districts in the education of disabled youth between the ages of six and twenty-one, and the Division of Vocational Rehabilitation provides authorized services to eligible disabled youth and adults.

The State Department of Education has long felt that there is no segment of its program more important than the training and rehabilitation of disabled young people who have before them the possibility, with adequate services, of a full and productive life. Major attention is, therefore, being directed toward effecting a comprehensive and coordinated program between special education and vocational rehabilitation, which have strong common bonds and objectives, with the view of bridging the gap between special education and the world of work.

Concept of Services

The Division of Vocational Rehabilitation has given increased emphasis to providing appropriate and needed services designed to assist physically and mentally handicapped young people in making a more effective transition from a protective school or institutional environment to a workaday world.

All of their efforts met with a degree of success. However, it became increasingly clear that one of the most effective and economical ways of preparing substantial numbers of handicapped youth for suitable and productive work would be through a cooperative working arrangement with special education on a State and local level. The soundness of such an approach is being demonstrated through the replication of programs already successful in several states, involving the cooperative effort of the Division of Vocational Rehabilitation and the Bureau of Pupil Personnel and Special Educational Services of the State Department of Education and the Hartford, Norwalk, and several western Connecticut school systems. In addition to providing a needed service at reasonable cost, the plan has gained school and community acceptance as well as statewide recognition. It has been planned to serve as a bridge between school and employment, eliminating the long and deteriorating waiting periods, and provides a means for individuals to become socially adequate and productive members of society.

Out of our experience has come a wealth of knowledge on which to project future program operations.

Traditional Program

In Connecticut, as in most states, school programs for young physically and mentally retarded adults are essentially academically oriented, with stress on the specific educational needs imposed by the nature of the handicapping condition. Legally, they are obligated only to provide an educational program without any mandatory emphasis on vocational training. Activities outside the academic area were directed toward social maturity, self-care, communication, social competence, and self-direction. Crafts, adapted shop activities, and homemaking activities were included only as they seemed appropriate to the needs of individual students. There was no provision, however, in the school setting for:

1. Vocational diagnosis and evaluation of employment potential by and with vocational rehabilitation staff
2. Arrangement of actual job try-out and job training under the supervision of vocational rehabilitation staff
3. Job placement and supervision by vocational rehabilitation staff
4. Coordination of a developmental program for special education students prior to coming into special rehabilitation programs, specifically:
    - a. curriculum planning for a developmental program for special education departments jointly with experienced vocational rehabilitation staff, for use by special education in training students prior to entering the special rehabilitation program (unit).
    - b. planning jointly with vocational rehabilitation staff for full utilization of existing services within the local School district for special education students, namely
        - (1) Crafts - to develop vocational interest and dexterity
        - (2) Social Activities - to enable clients to develop social relationships, such as they would encounter in a work setting
        - (3) Homemaking Activities - to provide personal adjustment training or vocational training for the vocational objective of Homemaking
        - (4) On-campus Job Training
            - (a) with school nurse
            - (b) in school garage
            - (c) in school cafeteria
            - (d) with school custodian, etc.

Rationale for the Connecticut Plan

Inasmuch as past studies and reports indicated that the physically and mentally handicapped lost jobs more often by their failure to adjust to a work situation than through their inability to perform the job, per se; and, inasmuch as our studies also indicated that failure in job training and employment was primarily due to lack of supervision in initial training and/or employment periods, there seemed to be a pressing need to supplement current available services to provide handicapped youth with the kinds of vocational experiences and supervision which would help them past this pitfall.

Although the Educational Work Experience program has made a major contribution, there is still a definite urgency for providing these young people with an appropriate environment, suitable activities, suitable job training stations, and suitable places of employment, carefully supervised and selected for the purpose of:

1. evaluating, studying, and developing vocational potential
2. exploring individual adjustive and learning problems in relation to vocations, through a sampling of suitable work experience
3. developing dependable work habits
4. observing personality traits in a work-world atmosphere, in order to nurture socially acceptable behavior in job training and employment
5. Extending the program so that the young adult can proceed to on-the-job training, part-time employment, or a full-time job within the framework of the school setting and vocational rehabilitation

The Connecticut Plan (Program)

The Division of Vocational Rehabilitation and the Bureau of Pupil Personnel and Special Educational Services of the Connecticut Department of Education will establish, in cooperation with school systems within the State, special vocational rehabilitation services at the secondary school level. The primary purpose will be to provide, on an organized and systematic basis, appropriate and needed vocational rehabilitation services to all eligible physically handicapped and mentally retarded boys and girls who, because of their diabilities have or will have an employment handicap, as authorized in the State Vocational Rehabilitation Plan.

The establishment of these services and the operation of the program is facilitated by the fact that vocational rehabilitation and special education programs at the State level, are both administered under policies adopted by the State Board of Education.

Operational Plan

I The plan includes two separate programs, but so related as to provide continuous and uninterrupted service. They are:

A. Special Education - Primary control and responsibility of this part of the total program is vested in the Bureau of Pupil Personnel and Special Educational Services and the cooperating school district. Activities which are currently, traditionally and legally, the function of Special Education, not specifically assigned to the Vocational Rehabilitation Division (as enumerated herein), will be the responsibility of Special Education.

B. Vocational Rehabilitation - The operational aspects of the program, as they relate to that phase of total program, which are currently, traditionally, and legally the funstions of Vocational Rehabilitation will be the responsibility of Vocational Rehabilitation. Authorized rehabilitation services will be provided under conditions stipulated in the State Plan for Vocational Rehabilitation.

C. Responsibility - In setting up a program of this type and scope, it is recognized that certain services to the mentally retarded and physically disabled youth can legally be the responsibility of both Special Education and Vocational Rehabilitation. The very nature of the problem and the common objectives make this so. It is believed the program will provide a continuous and uninterrupted service through "common areas" without duplication or encroachment of one division on the legal responsibility of the other. It should mean an enrichment of the separate programs of each division and save substantial sums of public money.

D. Staffing

1. Special Education personnel having program responsibilities:

Chief, Bureau of Pupil Personnel and Special Educational Services

State Consultants of Special Education

Other Consultants employed by the Bureau of Pupil Personnel Supporting Staff

In addition to their regular duties they will serve as consultants and supervise those activities which are primarily special education in nature, as distinguished from vocational rehabilitation services. The Chief of the Bureau of Pupil Personnel and Special Educational Services, will, among other things, approve the establishment of the units.

Except as provided under Section XI, "Financing", expenduture for salaries and related costs will be paid by Special Education at no cost to Vocational Rehabilitation.

2. **Vocational Rehabilitation personnel having program responsibilities:**

    Director, Division of Vocational Rehabilitation

    Chief, Bureau of Rehabilitation Services

    District Supervisors, Division of Vocational Rehabilitation

    Vocational Rehabilitation counselors assigned to facility services

    Other consultants employed by Division of Vocational Rehabilitation

    Supporting staff

In addition to their regular duties, they will serve as consultants and supervise those activities which are primarily vocational rehabilitative in nature, as distinguished from special education. The Director, through the assigned counselors or other rehabilitation staff, will, among other things, determine eligibility of all clients. He will authorize all vocational rehabilitation expenditures, determine nature and scope of rehabilitation services to be provided, approve all staff rendering vocational rehabilitation services, accept and approve funds allotted to Vocational Rehabilitation activities and expenditures.

II Key Staff Persons

The two key staff persons involved in the operation of the vocational rehabilitation aspects of the program are:

A. The Vocational Rehabilitation Counselor assigned to Special Education program. His major duties and responsibilities are outlined herein. He is a regular rehabilitation staff member and functions as such.

B. The Vocational Adjustment Coordinator. His major duties and responsibilities are outlined herein. He will function as a regular rehabilitation unit staff member in rendering vocational rehabilitation services as distinguished in the Plan for Special Education Services. He is subject to the qualifications and standards which apply to all certified professional personnel of the school system. He must hold a Special Education Teacher's Certificate issued by the State of Connecticut.

III Location of Facility (Class) or Program

The facility known as a secondary class is to be located on a senior high school campus in any given public school within the State of Connecticut. Due to the organizational pattern of some public schools, however, it may be necessary for the facility in some instances to be located on a junior high school campus. It is understood that many of these students will be incorporated right into regular, ongoing classes, attended by all other students, such as home room assignments, physical education, sewing, woodshop, etc.

IV Approval of a Rehabilitation Facility

A. Any independent school district may apply for a special rehabilitation unit through application to the Bureau of Pupil Personnel and Special Educational Services, by May 1, for activation the succeeding school year, September 1.

B. Minimum requirements for approval of a rehabilitation unit through Special Education are:

1. Anticipation of no less than 35 students who will have attained the minimum age of employment established by State statutes after the rehabilitation services are com-

plete to warrant setting up a rehabilitation program.

2. Designation of a vocational adjustment coordinator

3. Meeting other requirements as set forth by the State Department of Education, such as certification of coordinator, necessary teaching equipment, classroom facilities, furniture, etc.

C. Minimum requirements for approval by the Division of Vocational Rehabilitation:

1. All persons accepted for services shall be clients of the Vocational Rehabilitation Division, meeting the eligibility requirements set forth in the State Plan, and specifically:

    a. Classified as mentally retarded to the extent of constituting a vocational and employment handicap.

    b. In order to be a potential client, it is reasonable that, upon completion of services, the individual must be 16 years of age. An example of a case where this would be true, would be a 14 year old requiring two years of rehabilitation services to reach a vocational objective. Such a client would be in an age bracket where a vocational decision might reasonably be made. Only when a documented vocational rehabilitation plan has been submitted and approved by the District Supervisor, will a client under 16 be considered for the program.

    c. There must be a reasonable expectation that the stucent-client will be able to engage in productive employment.

    d. Services to be provided are such as would come within the nature and scope of the Connecticut Vocational Rehabilitation Plan.

2. The selection of personnel for, the assignment of personnel to, separation of personnel from the rehabilitation unit will be the primary responsibility of the superintendent of schools in the respective school system(s). The selection and the assignment of the vocational rehabilitation counselor for the rehabilitation unit, which is done by the Division

of Vocational Rehabilitation, must meet the approval of the Superintendent of Schools. However, the foregoing is subject to the final approval of the Division of Vocational Rehabilitation.

3. Personnel assigned to the rehabilitation unit by the school system, would work under the direct supervision of the Division of Vocational Rehabilitation and be subject to the same or equivalent qualifications and tenure standards applicable to the employe of the Division of Vocational Rehabilitation. Direct supervision by the Division of Vocational Rehabilitation in this requirement refers to establishing eligibility of clients, making rehabilitations plans for clients, and authorizing expenditures for clients receiving services from the vocational rehabilitation unit. It is to be understood that insofar as the operations of the program involve cooperation with the school system(s) and the school system personnel, the rehabilitation unit will operate under the administrative control of the school system, although only the Division of Vocational Rehabilitation has direct responsibility for the authorization of expenditures.

V. Duties of Key Personnel

A. A Vocational Rehabilitation Counselor will be assigned to specific schools to supervise rehabilitation program operations. His duties, among other things, shall be:

1. Register potential clients in referred status
2. Consult with school officials on training arrangements within the participating school districts for those services that will be without cost to the Vocational Rehabilitation Division.
3. Provide individual counseling to trainees found eligible for DVR service

4. Provide vocational rehabilitation services such as those listed in paragraph VII, "Direct Services Available" - to the individual trainees when extended services are needed and are not offered within the unit

5. Receive and evaluate, from the public schools, all records pertaining to those individuals accepted for rehabilitation services.

6. Initiate and conduct joint conferences with the vocational adjustment coordinator amd school staff in screening applicants and providing services. These staff conferences should be weekly, at the onset, in order to enable the staff members to share experiences in the unit, thereby encouraging the staff to function as a team.

7. Approve all job training. He shall evaluate training facilities, make training arrangements and agreements, advise with the trainer and vocational adjustment coordinator when indicated

8. Authorize all expenditures for client services

9. Approve all individual vocational rehabilitation plans for clients accepted for vocational rehabilitation services

10. Maintain individual case records of Division of Vocational Rehabilitation clients

11. Cooperate in securing job training stations and supervision of on-the-job training with the vocational adjustment coordinator and act as liaison person between the local community and the school program.

B. A Vocational Adjustment Coordinator will be assigned to each participating unit. His duties are:

1. Coordinate program with vocational rehabilitation counselor assigned to the local school district

2. Maintain class records and reports required of all special education teachers

3. Participate in joint conference with the vocational rehabilitation counselor and school staff in referral of applicants enrolled in regular school program for rehabilitation services

4. Secure job training stations and supervise on-the-job training. (This would be the primary duty of the Vocational Adjustment Coordinator, although final approval of the job station would be the responsibility of the DVR counselor)

5. Formulate reports of successes and failures with the vocational rehabilitation counselor, using this information to adjust program of services and evaluate program operation

C. The Principal of the cooperating school, from which the rehabilitation unit operates, will be charged with the following:

1. Administration of Special Education Program
2. Coordination of existing services within the school district with special rehabilitation program in order to facilitate and expedite the cooperative program and prevent conflicts between Special Education and Vocational Rehabilitation
3. Coordinate existing services within the school district, such as,
    a. recreational activities
    b. attendance regulations
    c. disciplinary regulations
4. Arrange for housing of programs
5. Regulate working hours of school faculty in compliance with school policy
6. Provide access to school records and school evaluations
7. Provide for building maintenance, custodial help, utilities, etc.
8. Furnish general consultative assistance as needed

VI General Sample Areas for On-the-Job Training

. Service Stations	- Porters	- Frontmen Helpers
. Grocery Stores	- Sackers	- Carryout Boys
. Cafeterias	- Kitchen Helpers	- Bus Boys & Girls
. Hospitals	- Ward Attendants	- Kitchen Helpers
. Furniture Stores	- Warehouse Helpers	- Delivery Helpers
. Warehouses	- Delivery	- General Helpers
. Upholstery Shops	- Strippers	- Trimmers
. Cafes	- Kitchen Helpers	- Bus Boys
. Drug Stores	- Fountain Helpers	- Delivery Boys
. Hardware Stores	- Stockroom Helpers	- Limited Customer Servic
. Carpenter Shops	- Helpers	- Clean-up Men
. Any business that offers prospective employment		

Flexibility will be essential in order to meet fully the needs of individual student-clients.

VII Direct Services Available Through Division of Vocational Rehabilitation

A. Counseling and Guidance

B. Training fees, tools, and equipment if required

C. Psychological services, when not available through the public schools, will be provided

D. Psychiatric evaluations will be made available as needed

E. Medical evaluations will be furnished, as well as physical restoration services, if not provided, or available through other sources

VIII Community Planning Participation

The Division of Vocational Rehabiliation and the Bureau of Pupil Personnel and Special Educational Services will concentrate and work with carefully selected plans for disabled clients, particularly those with severe involvements. Adequate community planning and participation are fundamental to the success of present and future management of the problem of mental retardation. In the absence of this cooperation, the community suffers, and the retarded, physically and/or emotionally handicapped will become unfortunate social and financial burdens. Proper community planning will enable society to absorb as useful citizens the greatest possible number of retarded, physically and/or emotionally handicapped individuals.

It is anticipated that local advisory committees will be employed to the maximum in this joint undertaking. Coordination of community resources will be the responsibility of the vocational adjustment coordinator and vocational rehabilitation counselor. They shall make use of available community resources, such as:

Council of Social Agencies
Connecticut Employment Service

Local Council for Retarded Children
Local Child Guidance Clinics
Local Society for Crippled Children
United Cerebral Palsy Workshop
Goodwill Industries
Local Business Men and Merchants

IX Evaluation - By Vocational Adjustment Coordinator, Vocational Rehabilitation Counselor, and Trainer and/or Employer

A. Students

1. Personal Adjustment
2. Pre-vocational
3. Job Tryouts
4. Progress in Job Training
5. Progress in Employment

B. Project - The Vocational Adjustment Coordinator will be charged with day by day supervision of individuals. Each independent school district will maintain records so that an over-all picture of statewide progress, as well as individual progress, can be compiled at the end of any given period.

X Records and Reports

The State Department of Education and each independent school district will maintain appropriate accounts and records for reporting to the Division of Vocational Rehabilitation and for audit purposes, and make such reports as may, from time to time, be reasonably required.

XI Financing

SCHOOL SYSTEMS

Non-matching:

Certain expenditures will be the sole responsibility of the school systems, including salaries of principal and other participating personnel, and training and other costs which are part of the school curriculum. Such expenditures will not be considered State funds for matching purposes.

For Purposes of Matching:

The matching items to be used will be items considered as discretionary rather than obligatory. Each school system participating will allocate funds to pay the salary of the special education teacher (Vocational Adjustment Coordinator), the establishment of facilities, i.e., provision of space, maintenance of space, and utilities.

Upon written documentation certifying the salary and fringe benefits to be used for matching funds, the Federal matching share will be allotted to the District Offices to facilitate processing of rehabilitation documents. The personnel utilized for this will be reported on Form R-400 quarterly, as required.

These Local Funds will not actually be transferred to the Division of Vocational Rehabilitation. The expenditures certified will be for the operation of that part of the program authorized under the Connecticut Vocational Rehabilitation Plan as described herein. They will constitute actual expenditures certified by the school system for purposes which the Division of Vocational Rehabilitation designates and under circumstances of which it is fully cognizant. Such certified expenditures reported on July 1 of each year by the participating school systems will be considered State Funds derived from public sources for Federal matching purposes by the Division of Vocational Rehabilitation.

VOCATIONAL REHABILITATION

The Division of Vocational Rehabilitation will make such additional expenditures as may be required in providing necessary administrative, consultative, supervisory, and counseling services, together with case service cost for clients of the Division. Such expenditures will be made from regular Vocational Rehabilitation funds, including State and Federal share.

To facilitate the development and operation of the proposed program, the State Bureau of Pupil Personnel and Special Educational Services and the Division of Vocational Rehabilitation, and the independent school systems will execute a written agreement. Copies of the plan are made available to each participating school system.

In order to implement the third-party financing from a local school system, a "waiver of statewideness" of the State Plan has been approved by the State Board of Education.

GRIFFIN HOSPITAL - LOWER NAUGATUCK VALLEY

HEALTH EDUCATION DEMONSTRATION PROJECT

A brief survey was made of the relationships between the DVR and services to the mentally ill offered by the Department of Mental Health and offered generally in the community.

With the Department of Mental Health, the request for a recommendation from the central office and the Social Service Chiefs is not available. The suggestion was made by Mr. Conklin that a statement of agreement formalizing the various arrangements in local hospitals might be helpful. Certain definitions such as what is "sheltered work" might be clarified.

Members of the mental health institutions were contacted by phone. We understand that there is a variety of programs run by DVR, indicated best, perhaps, by the number of full-time DVR Counselors listed here as being in the institution. The fact that the information was gathered from various sources leads to inaccuracy, and also tends to substantiate the desirability of one central source within the Department of Mental Health where this could be found. Mr. Gallotti of DVR was helpful.

Norwich	2 full time Counselors
Connecticut Valley	2 " " "
Blue Hills	1 " " Counselor
Fairfield Hills	1 " " "
Connecticut Mental Health Center	1 " " "
Undercliff	1 part time Counselor
Northampton V.A.	2 Counselors twice a week

Important mental health work is carried out by DVR Counselors at Hartford and Yale-New Haven Hospitals, and at Cedarcrest (with alcoholics and narcotics), on a formal part-time arrangement, and many general hospitals and other facilities have DVR Counselors assigned to cover on call.

Those Counselors working with the emotionally disabled do not have any specific meetings or training sessions beyond general sessions provided by the Division Staff, and what they pick up in their own locale.

Throughout the State, it is evident that there is tremendous advantage to there being "on-the-site-availability" of a DVR Counselor. In the larger institutions, the programs seem marred only by frequent personnel turnover and, in some cases, conflict over the jurisdiction of district offices when institution and hometown are in separate districts. It would appear that a written understanding might rectify this.

In the community services, (i.e., short term hospital stay at a general hospital or mental health center), other problems were noted, as follows: delay in acceptance of a case, sometimes stated as "too much paper work"; the need for more immediate job placement and the lack of understanding or coordination with the units or special counselors in the Connecticut State Employment Service; the apparent bias against mentally ill people by employers, and some C.S.E.S. counselors. (There are indications that some DVR Counselors don't seem to know how to work with the mentally ill.) There appears to be a need for consultation services to community people who are doing the counseling of many emotionally disabled people, and the possibility of using group techniques or adult educational programs to reach more people faster. The sudden lack of money to conduct the program is an annual occurrence which appears not to be planned for.

Could C.S.E.S. and DVR provide easily available and readily accessible job finding that does not stigmatize the mentally ill? Can educational services and DVR offer group programs in training or preparation? Can the "delay" be reduced, particularly to meet the crisis in the community? Inter-group relations must be improved between the job finders or placement people, and the mentally ill, minority group members, or socially and emotionally deprived indivividuals. Selected group dialogues or other such sensitizing activity could be instituted, aimed at the job seeker and the job giver.

May 16, 1968

Richard K. Conant, Jr.
Project Director

TECHNICAL ADVISORY COMMITTEE ON INTER-AGENCY COOPERATION

Chairman

Lorraine R. Loiacono
Chief, Medical Social Services
State Welfare Department

Herbert A. Anderson, Executive Vice President
Connecticut Hospital Association

Sholom Bloom, Executive Secretary
Commission on Services for Elderly Persons

Richard K. Conant, Jr., Project Director
Lower Naugatuck Valley Health Education Demonstration Project
Griffin Hospital

Arthur Dubrow, Director Community Services
Office of Mental Retardation
State Department of Health

Joseph P. Dyer, Director Program Management & Supporting Services
State Department of Community Affairs

Joseph R. Galotti, Assistant Chief
Bureau of Rehabilitation Services
Division of Vocational Rehabilitation
State Department of Education

Harold Hegstrom, Administrator
Jail Administration
State Department of Correction

Kenneth Jacobs, Consultant for the Physically Handicapped
Bureau of Pupil Personnel and Special Education Services
State Department of Education

Nicholas Leaycraft, Staff Supervisor of Services to the Handicapped
State Employment Service

Miss June Sokolov, Executive Director
The Hartford Rehabilitation Center

Kenneth Smith, Acting Chief
Public Health Social Work Section
State Department of Health

Miss Josephine Verrengia, Medical Work Consultant
State Welfare Department

George Walker, M.D., Coordinator
Comprehensive Health Planning
Department of Health

REPORT AND RECOMMENDATION
TECHNICAL ADVISORY COMMITTEE ON RESEARCH

To have completed a survey of the research activities of the numerous agencies listed in the fifty-nine page Directory of Rehabilitation Sources in Connecticut would have been a formidable task for this committee within the time available to it for completion of its mission. If there were added to this list the hospitals, industries, and commercial establishments within the State engaged in or concerned with rehabilitation-related research, the task would increase to proportions of impossibility. Some estimate of the range and variety of research activity within the State may be developed from information provided by the U.S. Department of Health, Education, and Welfare, and summarized here in Table I. It is evident from inspection of this table, that, in several categories of R.S.A. funded research, there neither has been, nor is, application of the numerous relevant resources with the State. This summary cannot, however, be accepted as definitive evidence of paucity of research activity. It must be assumed that some rehabilitation related research is supported by funds from other sources, and that some is conducted as a part of agencies' operations, without benefit of separately identifiable funds. The consensus of this committee is that, in view of the complexity and magnitude of the task, compilation of information on research activity should be a continuing process to assure a means of identifying needs and establishing priorities in the conduct of studies.

In its deliberations, the committee concluded that research is essential to assure efficient operation of the Division of Vocational Rehabilitation in terms of use of time, effort, and money, and of conservation of human resources. Accordingly, it strongly recommends establishment of an office of research within the Division, with such office to function as indicated in the following recommendations:

I. So that appropriate administrative officials may respond to the current needs in rehabilitation, there should be a permanent Advisory Council on Research, the responsibilities of which would include policy and operational consultation in identification and conduct of rehabilitation research.

To improve coherence among the various bodies within the State either engaged or interested in rehabilitation research, and to assure that programs of the Divisions' Office of Research is responsive to evolving needs, composition of the Advisory Council should include representation from the University community, the Division of Vocational Rehabilitation, the State Research Commission, private and community agencies, and industry and commerce.

II. The Director of the Office of Research should be directly responsible to the Director of the Division, and should serve as Executive Secretary of the Advisory Council.

III. The activities of the Office of Research should include:

A. Operational studies on practices, innovations, and systems of the Division. Of particular import would be client follow-up studies.

B. Establishment and maintenance of a case registry to facilitate studies conducted either within the Division or by cooperating agencies. It is expected that such a registry could be initiated by systematic organization of present case referral files, augmented with data on disabled persons now collected by other State agencies.

C. Establishment and maintenance of a clearinghouse on rehabilitation research within the State. It is noted that the present practice of referral by R.S.A. to the Division of all grant application in the State provides the foundation for such a service. A clearinghouse is envisioned as practical way of both providing useful information to cooperating agencies and of identifying research needs.

D. Organization and conduct of research interchange sessions involving both practitioners and researchers. Such a system would encourage early utilization of research findings by counselors, and would stimulate researchers to attend to those problems for study identified by the practitioners. To serve as a resource for such training programs, steps should be taken by the Division towards development of a Research and Training Center. It is noted that a preliminary proposal for a Research and Training Center has been submitted to the R.S.A. by the University of Connecticut. Such a center could serve as a laboratory for the Office of Research, as well as being the research interchange resource.

E. Provision of supervised field work experiences for trainees in rehabilitation research. In view of the existence at the University of Connecticut of one of the few programs in the nation in rehabilitation research, such a function would provide for an unusual opportunity for collaborative efforts.

F. Encouragement and support of applications by cooperating agencies of studies identified by the Advisory Council as needed but beyond reasonable scope of the Office of Research.

IV. Provision should be made within its budget for adequate staff and operational costs to carry out the functions of the Office of Research.

Table I: Number of Research and Demonstration Projects in Connecticut Funded By Vocational Rehabilitation Administration 1955-1967*

Category	Completed	Current
Cardiovascular disorders	0	0
Cerebral palsy	0	0
Epilepsy	0	0
Mental and personality disorders	1	0
Mental retardation	4	3
Neurological disorders	0	0
Orthopedic disorders	1	0
Respiratory and pulmonary disorders	0	0
Speech and hearing disorders	3	0
Visual disorders	3	0
Other disabling conditions	0	1
Aging and chronic illness	1	0
Homebound disabled	0	0
Rural disabled	0	0
Workmen's compensation	0	0
Facilities	0	1
Evaluation, prediction, counseling and counselors	1	0
International exchange of information	0	0
Special studies	1	0
Administrative or program studies	4	1
Additional projects in vocational rehabilitation	0	0

*Source: U.S. Department of H.E.W. Vocational Rehabilitation Administration Research and Demonstration Projects, and Annotated Listing 1967.

TECHNICAL ADVISORY COMMITTEE ON RESEARCH

Chairman

John Cawley, Ph.D.
University of Connecticut
Rehabilitation Counselor Training Program

John S. Burlew, Ph.D., Director
Connecticut Research Commission

William M. Cowell, Pharmacist
Stamford Hospital

John Flannery, Research Analyst
Welfare Department

Harris Kahn, Ph.D., Director
Rehabilitation Research Training
University of Connecticut

Merton S. Honeyman, Ph.D.
Office of Mental Retardation

Alfred H. Horowitz, Director
Connecticut Labor Department

Wilson Fitch Smith, M.D., Member
Advisory Board for Hartford Rehabilitation Center

Leo Sperling, Director of Research and Evaluation Developmental Program
Board of Education, Bridgeport

FINAL REPORT OF THE LEGISLATIVE TASK FORCE

After two meetings of the membership of the Legislative Task Force, and conferences by the Chairman with key people in the Division of Vocational Rehabilitation and leaders in several other rehabilitation agencies closely affiliated with the division, the following specific recommendations are submitted for consideration:

1. That consideration be given to raising the Division of Vocational Rehabilitation to independent commission status. It was proposed that a bill be drafted and introduced at the 1969 session of the General Assembly which would establish the Division of Vocational Rehabilitation as a separate and independent commission, and that efforts be made to have this bill referred to the Legislative Council for study. As an alternative, in order to strengthen the position of the Division of Vocational Rehabilitation if it is to remain within the Department of Education, the Legislative Task Force recommends the establishment of a position in the Department of Education at the Deputy Commissioner level. It would be the function of such an individual to coordinate the rehabilitation program within the State Department of Education.

   REMARKS: The justification for the above recommendation came after considerable discussion concerning the inability each biennium for the Division to obtain sufficient money from the General Assembly for the needed expansion of services to handle the constant back-log of disabled persons who should be rehabilitated and placed in jobs. With the addition of the added case-load of the disadvantaged, it seemed especially urgent this year to make a move, not only to provide additional services, but also to impress on legislators the great economic advantage of putting disabled people to work. Owing to the great number of problems in education, today. it was felt that to continue to bury this Division within the Department of Education is neither practical nor desirable.

2. That a separate bill be introduced in the 1969 General Assembly which will remove the residence requirement for DVR service to those who need this service. This amendment will meet the conditions imposed by federal legislation for Connecticut to remain eligible to capture federal funds for rehabilitation services.

3. That amendments to present statute be submitted which will grant direct authority to DVR to implement federal programs in Vocational Rehabilitation for the disadvantaged in Connecticut.

There was general dissatisfaction expressed at both meetings of the

Task Force on the confusion among professional and lay people concerning the role of the Division of Vocational Rehabilitation and its responsibility to clients who are in state residential facilities or under the supervision of other state agencies. The Legislative Task Force does not feel that additional legislation will remedy this situation. However, the many task force members did recognize the need for much better inter-departmental planning, increased study of third-party financing, and a vigorous public education program to acquaint the state agency administrators, the lay public, and state legislators with the economic feasibility of a dynamic rehabilitation program in this state. Finally, in addition to the three specific recommendations proposed earlier in this report, the Task Force suggested that unless there is an opportunity for the Division's budget to be presented and studied separately by the General Assembly, no real progress can be expected in termes of capturing additional federal monies or meeting the priority needs already documented in the Statewide Planning Report.

Ann Switzer, Chairman

TECHNICAL ADVISORY COMMITTEE ON LEGISLATION

Chairman

Miss Ann Switzer
Executive Director
Connecticut Association for Retarded Children

David K. Boynick, Assistant to the Commissioner
Mental Health Department

Raymond W. Brunell, Jr., Executive Director
Connecticut Association for Mental Health

Thomas Dowd, Jr.
Trumbull

Mrs. Glenn Farmer
Old Saybrook

Raymond Fitzpatrick, Executive Director
Waterbury ARC

Daniel Fletcher
State Commission on Human Rights and Opportunities

Joseph R. Galotti, Services Specialist
Division of Vocational Rehabilitation, Hartford

William F. Hill
Veteran Employment Representative
State Department of Labor

Mrs. Helen Loy
Loy Associates, Hartford

James F. Morrison, Chief of Staff Services
State Welfare Department

C. Perrie Phillips
Commissioner of Personnel
State Office Building

Dr. George Sanborn
Office of Departmental Planning
State Department of Education

Mrs. Gloria Schaffer, State Senator
Woodbridge

Dr. Wesley C. Westman
Statewide Planning Project for Vocational Rehabilitation Services

EDITOR'S NOTE

Much of the work of the Technical Advisory Committee on Job Market and Manpower, and the Technical Advisory Committee on Incidence of Disabilities consisted in serving in an advisory capacity to the Project Staff in the compilation of data. Their reports comprised, primarily, recommendations and their documentation, which have been incorporated in Volume I. Consequently, the reports of these committees will not be reproduced here. A list of the members follows:

TECHNICAL ADVISORY COMMITTEE ON THE INCIDENCE OF DISABILITIES

Chairman

Gertrude Norcross, Executive Director
Connecticut Society for
Crippled Children and Adults

John C. Allen, M.D. Physiatrist
Department of Physical Medicine
Hartford Hospital

Harold Barrett, M.D.
Deputy Commissioner
Public Health Department
Connecticut

H. Kenneth McCollam, Director
Board of Education & Services
For the Blind

TECHNICAL ADVISORY COMMITTEE ON JOB MARKET AND MANPOWER

Chairman

Joseph P. Dyer
Director
Program Management & Supporting Services

Stephen Berman, Director
Manpower Employment & Services
Community Renewal Team, Hartford

William Brown, Executive Director
Urban League, Hartford

Lewrence Carni
State Labor Department, Wethersfield

Frank Connell
The Bridgeport United Fund

Mrs. Mary M. Dewey, Director
Connecticut State Employment Service
State Labor Department, Wethersfield

Kenneth Ford, Secretary-Treasurer
State Building and Construction Trades Council, Wallingford

Thurman M. Fribance, Personnel Manager
R. R. Donnelly and Sons Company, Saybrook

Alfred H. Horowitz
State Labor Department

Nicholas Leaycraft,
Employment Service for the Handicapped

Harold LeMay
Pratt and Whitney Tool Company

Olof Lostrand, Vice President
R. R. Donnelly and Sons Company, Saybrook

Carmen Romano, Director
Dwight Project
Redevelopment Agency

Henry Silverman, Business Manager
Sheet Metal Workers' Local 40, Hartford

Roger Skelly
Connecticut State Employment Service

Richard Spector, Supervisor
Labor Information
Employment Security Division
State Labor Department

Richard Woodruff, President
Waterbury Central Labor Council, Wolcott

Thomas Yoczik, Chief
Apprentice Training Division
State Labor Department

RADIO, TELEVISION

AND

REPRESENTATIVE NEWS COVERAGE

INTERVIEW WITH WESLEY C. WESTMAN, PH.D.

AMERICANA
Station WTIC
October 13, 1967

Interviewer: Dick Bertel

INVESTING PUBLIC MONIES IN HUMAN RESOURCES

What are the costs? What are the dividends? We hope to answer these questions tonight with my guest, Dr. Wesley C. Westman, Project Director, Statewide Planning for Vocational Rehabilitation Services.

Question: Dr. Westman, what is the Planning Project for Vocational Rehabilitation Services designed to do?

Answer: It is designed to study the needs of the disabled citizens of Connecticut and how we can serve as many of them as possible in the near future. By 1975, our stated goal is to be serving all eligible disabled people.

Question: Now, what do you mean by disabled people?

Answer: The definition of disability has recently been changed. In the past, a disabled person was seen as a person who had a readily identifiable medical problem which could be corrected through surgery, or through some kind of medical service. These persons, if they were not able to return to their old jobs, were retrained and could then be returned to the labor force. At this point, -- since the 1965 amendments to the Vocational Rehabilitation Act, -- it has a much broader definition. It includes any mental, social, educational, or psychological barrier to employment. This means that we can serve a much wider range of people, and it means that we intend to serve those people, and the planning project is intended to answer the question, "How do we go about this?"

Question: In other words, a person might be handicapped because he cannot speak English, or he might be handicapped because he has absolutely no job skills. Am I correct?

Answer: That's right ... exactly. Any barrier to employment that can be corrected through the services of Vocational Rehabilitation is the rationale for providing services to people -- which is our primary business. These services may cover a wide range. They may include psycho-therapy... They may include purchasing tools and licenses... They may include technical education, even college courses. They may include any service which we can defend in terms of the person's later ability to be productive and to return tax monies to the Federal and State governments, sometimes as much as five or ten times the amount that was invested in him.

Question: Under this broad definition of disability, how many disabled people, would you estimate, there are in Connecticut?

Answer: A recent study demonstrated that there were, as of 1965, somewhat over 56,000 in terms of a backlog of eligible people in the disability categories which we serve. The same study estimated an annual increment of better than 5,000; so this would put it up around 66,000, at this point. This represents the number of people presently in those categories. We are not able to serve that high a load. Connecticut has a high caseload now. We are serving a large number of people, however. Approximately 1,550 people in the State of Connecticut were successfully rehabilitated last year, and I believe the total caseload was around 4,000 persons. By 1970, we hope to have the caseload increased to 10,000, which will, perhaps, bring the rehabilitations up to 5,000 per year. By 1975, our stated goal, if we are able to attain it, is for all disabled people in Connecticut to be receiving services. That would put it up close to 100,000 people, which may, very honestly, be a conservative estimate.

Question: Again, under this broad definition of disability, it would seem to me that many of your so-called disabled people would be from the ghetto areas of the cities.

Answer: That is right. Where there are unemployment and low job skills, very often these are part of the vicious cycle of poverty. Social dependency and poverty go hand in hand, whether it is in Hartford, Appalachia, or wherever. To interrupt this cycle of poverty, one of the best methods I know is to provide individuals with a saleable skill that will not become obsolete in the near future so they may escape the cycle that they are in.

Question: We hear the term "hard-core unemployed". Do you think it is possible to reach these people, to assist these people with job skills for the future?

Answer: I have to think that is possible, otherwise I wouldn't be doing the work I am doing. You have to be realistic, at the same time, and say that there are numbers of the "hard-core unemployed" who, perhaps, with our present level of functioning knowledge or skills, cannot be rehabilitated by us. There was a cooperative project in West Virginia between the Department of Welfare and the Division of Vocational Rehabilitation, and I recall... I think that, during the first year of their program, they rehabilitated successfully 50 of the "hard-core unemployed". I am not sure... I think they served around 300 ... Well, that's not an excellent batting average, but it was the first year of the project. I think they were doing better the second year, but this means 50 more people rehabilitated than before the project was begun. I think these projects are possible all over the country, and I think it is going to take the cooperation of a number of State agencies. I think that it is going to take the cooperation of the business and industrial communities, in terms of providing guidelines for public agencies as to the kind of people they need, as to the kind of training programs they are willing to help out with in this kind of program.

Question: Well, it would seem to me that, with 50 rehabilitated out of 300, their return of money to the economy would more than pay for whatever it cost to work with those 300 persons.

Answer: That is exactly it; and I think that is why we can sell the program of vocational rehabilitation so easily, because it is to everyone's interest. It is to the interest of the individual we are serving, first and foremost, because he can become employed and can have a growth of self-respect and human dignity, which is what it's all about. It is to the interest of society because it has gained a taxpaying citizen who is concerned about the problems of the community, -- helping other people out of the cycle that he was in. It is to the interest of the public agency because that is what it is in business to do: to serve people in the interest of society.

Question: Now, can industry, itself, assist the public agency, do you feel, more than it has?

Answer: I have to be fair to industry... I think that it has done much more in the recent past, -- in the last five years, for instance, -- as with industry's cooperation in the Job Corps Program, as in industry's expressed willingness to set up special training programs. One instance I can think of is that the Industrial Launderers Association set up a special training program for the mentally retarded in which they were trained to work in laundries. This was set up, partly with tax dollars, partly with the dollars of the industrial group, and the result was that a lot of mentally retarded people were served and they will be placed on jobs.

Question: You are a psychologist, Dr. Westman. I recently talked with an employer in a small manufacturing company who said that a major problem was getting these people to come to work consistently. Now, is there, also, besides the teaching of a skill, the responsibility of teaching people attitudes toward work?

Answer: Exactly, and that is a very good point. I think this is primarily the result of a big difference in value systems. The average middle class white person watches the clock. When he says that he will be there at 8 o'clock, he will be there at 8 o'clock, as a general rule. The average person who lives in the ghetto, -- whether he is Negro or not, whether he is white, Puerto Rican, or whatever, has a different sense of time. For a person who has been unemployed for six years it is difficult to get up at 6:30 or 7 o'clock in the morning and be at work exactly on time, because of his habit pattern. In vocational rehabilitation there is a phase called pre-vocational training, and this is precisely what this does. It allows the person to become gradually accustomed to work habits: to responding to the orders of the supervisor, to showing up on time for work and to leaving on time, and to not extending his coffee breaks unreasonably, etc. In other words, people have to be worked slowly into a new habit pattern. You do not, all of a sudden, get up one morning and you are a working person... There are a lot of quite complex behaviors and attitudes associated with being completely employed. In Vocational Rehabilitation, I think they have handled this very well. A lot of work is done in Sheltered Workshops with disabled people, in this respect, in terms of just getting them used to all the habit patterns they will need, to be on the job.

Question: Do you see this project and the future vocational rehabilitation work to be done as a deterrent to those conditions which are producing riots in our major cities?

Answer: I think that education and employment are two of the major issues that the people in the ghetto are talking about now. I think that there have been a lot of other irrelevant issues which have been cast aside. Housing is a third issue. Vocational rehabilitation would have little influence on that problem, but it would have on employment and on education, and if it makes an impact on those basic problems, then it will make an impact in terms of the attitudes of the people who live there. I think the white community has realized, in the past few years, that Negroes do, Puerto Ricans do, ghetto people do want the same things that the white community wants. They want a job, they want a house, they want a car, they want to be responsible and respected individuals. They want to have self-esteem, and I think that while we can't claim to be the panacea (because I do not think there is one), I believe that rehabilitation, as a field, may claim to have the machinery already set up to accomplish a great deal in this area.

Mr. Bertel concluded: "It would seem to me that one would certainly not want to destroy a society in which one has a stake, and perhaps vocational rehabilitation is the answer to the problem facing us today.

"Dr. Westman, I want to thank you for visiting with us, here on Americana. -- We have been talking with Dr. Wesley C. Westman, Project Director, Statewide Planning Project for Vocational Rehabilitation Services. Thank you."

Dr. Westman: "It's my pleasure."

WTIC presents "Your Community". Today, a progress report on the Statewide Planning Project for Vocational Rehabilitation Services. Here, to introduce his guests, is WTIC newsman, Paul Hayes.

Mr. Hayes: Earlier this year, the Governor's Planning Council began a study vocational services throughout Connecticut. The study is being conducted under a Federal grant and will include an assessment of rehabilitation needs in the State, along with recommendations to the Legislature for possible action. Our guests are Dr. James S. Peters II, Director of the Division of Vocational Rehabilitation of the State Department of Education; Frank C. Grella, Assistant Director of the Project and Associate Professor of Management at the University of Hartford; and Miss Lorraine Loiacono, Chief of Medical Social Work Services for the State Welfare Department. I am Paul Hayes.

Dr. Peters, what is vocational rehabilitation; who needs it and who gets it?

Dr. Peters: Vocational Rehabilitation is a program of services to the handicapped people of Connecticut, especially those who are approaching working age, at approximately sixteen years of age. These handicaps, we find, fall within the categories of the physically handicapped, mentally handicapped, and now may include the socio-economically, educationally disadvantaged handicapped. All individuals who are eligible for vocational rehabilitation are served, usually by our various local and district offices.

Mr. Hayes: About how many people, Dr. Peters, are involved in this at the present time?

Dr. Peters: If we are speaking of the people who are in *need* of the services, -- we would have, roughly, about 50,000 persons involved. As far as those actually being served through our offices, there are about 6,000 at the present time, and these are people who are being helped to get jobs, to get an education, to get medical attention, and various other things which they need. Now, we certainly look to the final disposition of these cases; that is, when they go to work. These are our rehabilitants. We have about 2,000 individuals at this time who have been rehabilitated to work.

Mr. Hayes: About how much money does this represent?

Dr. Peters: This represents an outlay of approximately $5,000,000, when we consider *all* of the services, of which the Federal government pays seventy-five per cent.

Mr. Hayes: Why do you think, Dr. Peters, that the State should be involved in this kind of project?

Dr. Peters: Well, there are a number of reasons, Paul, and the very first is because we make taxpayers out of potential tax recipients. Especially when we look at the vast number of injured workers, the vast number of people who, because of some chronic disease or illness, would not be able to work unless they had these services, we might ask, where would they land? They would land on charity. They would, certainly, fill the welfare rolls.

Mr. Hayes: We do have a Statewide Planning Project for Vocational Rehabilitation at this time. I would like to direct the next question to Mr. Orella. Can you tell us a little bit about this project; how does it work?

Mr. Grella: The Statewide Planning Project began in 1966, and its purpose is to assess the total extent, if possible, of the vocationally disabled, in the State of Connecticut. That might seem like a rather simple assignment, but, actually, it is not. Physical disability for an individual who is well-educated, who has a white collar type job, might be difficult to define. For a person who has a minimum of education and who must rely on his physical strength in order to earn a living, a physical handicap obviously constitutes a disability. To go one step further: as has been mentioned here, the socially, economically, and culturally deprived groups have not, as yet, been fully considered in this type of vocational rehabilitation program; and some of these people, in addition to physical disabilities, have these other types of disabilities to consider. Consequently, when we talk about "long term planning", which is the goal of the Statewide Planning Project Study, these considerations must be accounted for, must be considered, otherwise we will not have a long-term, effective program.

Mr. Hayes: When we think of vocational rehabilitation, I suppose a related field is the field of Welfare -- the work of the Department of Welfare. How does vocational rehabilitation affect the role of the Welfare Department, Miss Loiacono?

Miss Loiacono: We feel that Welfare is, very definitely, playing a significant role in rehabilitation, and that rehabilitation, itself, is not a new concept to us in Welfare, even though some amendments to the Social Security Act have placed special emphasis on rehabilitation. Actually, we feel close to Rehabilitation and almost a "member of the family",since, last year, the Secretary of Health, Education, and Welfare put both social and rehabilitation services in one agency under the administration of Miss Mary Switzer. In general, I would say that Welfare feels that it has a responsibility, over and above that of just meeting subsistence needs, to prevent dependency when this is due to illness or some social maladjustment; thereby helping individuals to achieve a maximum degree of personal, social, and economic independence. We, too, subscribe to the goal of employment in rehabilitation, but we feel, also, that for those by whom this goal cannot be attained, as much importance as possible should be placed for these people on the achievment of a maximum degree of self-care. This we find is true, for example, in helping a patient who has been bedridden, to walk; in helping a person to take care of his personal needs to the extent possible, without outside assistance. We feel that this is not only gratifying to the individual, but certainly is important to the agency having the responsibility for maintaining this person, from a financial point of view. This broad aspect of rehabilitation is really reflected in all of our services, but there has been special emphasis in the Aid to the Disabled program, and Aid to Families with Dependent Children programs, where disability and disease are largely responsible for dependency. Although rehabilitation is costly, it is not as costly as chronic disability. Rehabilitation has really done a great job, can continue to reduce dependency, and can certainly restore the dignity and self-respect of a person. If I may, I would like, just briefly, to tell you, specifically, of a work-training project we have had since 1963.

Mr. Hayes: Before we go into that, Miss Loiacono, a question on what you have talked about, so far: Is there any feeling, when you talk about agencies, programs, and costs, that, maybe, the Vocational Rehabilitation Program with its money needs, will take some of the money away from the Welfare Department which it might need; and if it does, is this really a bad thing? ... Might it more effectively accomplish some of the things which the Welfare Department has been struggling to do?

Miss Loiacono: I am not sure I understand what you mean, about taking money away from the Welfare Department.

Mr. Hayes: Well, there is only a certain amount of money available for any given fiscal period. If the Welfare Department is supported by the State, and the money has to come from the State... If you are dividing ten dollars among ten people, each gets a dollar, but if, all of a sudden, you are dividing it among twenty, each one gets a proportionally smaller amount. This is what I refer to.

Miss Loiacono: We have tried to cooperate with DVR, in the past, and we would continue to do so. We have, actually, provided a certain sum of money when we throught that this was the only way in which we could get matching funds from the Federal government. We had a very successful project about three years ago, on this basis. We certainly would not be reluctant to do it again, if this were necessary.

Mr. Hayes: Your feeling might be that Vocational Rehabilitation is a good supplement to the Welfare Department?

Miss Loiacono: I would certainly feel that it is ... Yes.

Mr. Hayes: You referred to a project which was started some years ago.

Miss Loiacono: Yes. I might just briefly mention that project, because it does show how we are involved with Rehabilitation. This was a work training project administered completely with Federal funds, Title V under the Economic Opportunity Act. The aim of this project was really to provide our "hardcore" cases with a constructive work experience, to help develop skills which would make them more employable. We found that, at the end of a year, many of our people were placed in employment, at a savings of $3,000,000 to the taxpayer. What we found was that we were really able to reach the so-called "unreachables" by tailoring a rehabilitation program to their needs, and by getting them in to some kind of work in which they were interested. We did use community resources, we worked hand in hand with DVR and the Department of Education, the Department of Labor ... we worked with many agencies. This was a very successful project, and we find that we are still being successful with this.

Mr. Hayes: Staying with the area of money problems, Mr. Grella, where is the money coming from for this Planning Project?

Mr. Grella: I think, perhaps, Dr. Peters might answer that question more appropriately.

Dr. Peters: Well, I've got the money, and Mr. Grella spends it. (Laughter) The money is being contributed, 100%, by the Federal government, through the Department of Health, Education, and Welfare Rehabilitation Services Administration. The cost is approximately $100,000 per year. This is a two-year program, into which all of the states of the United States, plus some of our possessions, have entered.

Mr. Hayes: The Governor's Council has been at work on this matter for some time. Is it felt that the Council has made progress in the study?

Dr. Peters: It has made tremendous progress; and I will throw this ball to Professor Grella.

Mr. Grella: Thank you. The study was based on a cross section of needs in the State as a whole, so we have had regional committees working in the five principal cities of the State -- Waterbury, New Haven, Hartford, Bridgeport, and Norwich. Each of these regional committees has submitted its recommendations for what it considers the needs in its particular region of the State. The Planning Council is now in the process of reviewing those recommendations, and if they come through strongly enough, they will be forwarded to the Department of Health, Education, and Welfare in Washington. It is hoped that, nationally, there will be a consensus as to what constitutes the needs of Vocational Rehabilitation. Therefore, a better program can be planned nationally and the State program will benefit from these studies.

Mr. Hayes: What kind of technical problems are encountered in doing such a study?

Mr. Grella: Well, I might mention the biggest problem which is, again, determining what constitutes a disability. There is the very obvious situation of an individual with a missing arm or leg and his particular kind of work needs that facility which he simply doesn't have. To determine what constitutes vocational disability is the principal problem; but another problem, which is of extreme importance, is how these services are apportioned to the various kinds of disability which present themselves. Do we stress, for example, services to people who are physically impaired, who have mental problems, mental illness? Do we stress services to people who are mentally retarded? What we hope will emerge from this Project are criteria and guidelines which will enable the Division of Vocational Rehabilitation in Connecticut, and in other states, hopefully, to know how to plan their programs so that maximum benefit accrues to the clients, and, at the same time, the State's investment in human resources has a yield, or "pay-off", if you like.

Mr. Hayes: I would mention that another problem area for any study of this type would be dealing with the people personally involved, those who need the vocational rehabilitation. Do you have any comment on this, Dr. Peters? How have these people been handled?

Dr. Peters: I think that, throughout the country, Paul, they have been handled in a highly commendable manner, especially when we know that a professional worker with the handicapped and disabled must be very well prepared, having, in many instances, a PhD. degree, a doctorate, although, in most cases, the Master's degree is the working degree, together with some experience for handling these clients. Aside from the academic preparation, we usually think that people who have "heart" are better enabled to work with the handicapped people, people who feel that every man has a role to play in society, that there is an adjustment which can be made, no matter what his limitations are; because, when a disability presents a barrier to work, it means that the individual is being hampered in terms of his dignity, in terms of his need to be a citizen who is independent and not dependent.

Mr. Hayes: When we talk about vocational rehabilitation, Mr. Grella, we almost automatically think of Business... at least, I do. I refer to the involvement of Business in trying to solve the problems of those who will be benefited by this program. Has the Planning Council looked into this area, and if so, with what results?

Mr. Grella: We have looked into the area of vocational rehabilitation, for example, with respect to the needs of the labor market within the State of Connecticut. In the fiscal year ending in June 1967, there were more than 1500 clients rehabilitated, and these went into a wide spectrum of jobs throughout the State, ranging from professional jobs to the service jobs and machine trades jobs, which are, as you know, experiencing personnel shortages in this area, as well as in the State, so there is a direct benefit to the industrial, or business structure, as a result of the program of Vocational Rehabilitation. Now, something which Miss Loiacono mentioned, which must also be mentioned here, is that the program also considers rehabilitation of those individuals who may go to work in so called "sheltered workshops", or may even become homemakers. The homemaker, in particular, who returns to a useful life in this kind of activity, may be able to release someone from that home who can then go out into the labor market. What I would like to stress here, although I think it has been stressed already, is that the overall program, while it has a strong humanitarian objective, also has a strong economic objective, and I think very often that this economic objective is over-looked by people who think, "Here is another charity program which is helping some individuals at the expense of others." Ultimately, if the program is successful, it does yield benefits to the State and to the Federal government.

Mr. Hayes: We talked about business, and you have suggested the possibility of people becoming homemakers. What projects, presently in operation, can lead to putting a person back into business or establishing a a person where she is capable of being a homemaker?

Mr. Grella: I'd like to refer this question to Dr. Peters.

Dr. Peters: I am aware of several such programs which are going on throughout the State. In particular, we have a project in Bridgeport, in cooperation with the Bridgeport school system, wherein, under a special demonstration grant from the Department of Health, Education, and Welfare, Rehabilitation Services Administrator Dr. Paul Lane and his workers are involved in helping young people to graduate, in terminal programs though the Bridgeport school system, and in a special vocational training program, to get established in business. I could tell you more about it if we had the time. Then, we also have, in the various comprehensive Rehabilitation Centers, in places like Stamford, New Haven, and Hartford, Homemakers Programs being sponsored and supported by Vocational Rehabilitation, where the handicapped homemaker is helped, through the rehabilitation services that go on in the Rehabilitation Center, to go back into the home and take care of the family.

Mr. Hayes: There are, undoubtedly, problems still to be met in each of your areas. I am sure you can think of these almost immediately. First, Miss Loiacono, in the area of the Welfare Department, what are some of the problems you feel the Planning Council should delve into? And what do you think the Planning Council should do about these?

Miss Loiacono: I feel that one of the things I would like to see is a re-definition of rehabilitation. I would like to see it broadened to enable us to help any individual with a problem; not necessarily one due to illness, but one due, perhaps, to social maladjustment, any problem which would interfere with his ability to achieve the greatest level of personal and social well-being and self-sufficiency, rather than have the objective limited to that of employment and self-support.

I would also like to think of having an identification of all services in a given community, and all employment possibilities made available to those who are working with the handicapped in any way. I would like to see us working more closely with employers, getting them to understand that the handicapped can do a job, to see if they can be hired, as long as they can do the job; not to think of the handicap but rather of what the person is capable of doing.

I would like to see more staff workshops between agencies, for an exchange of program information, and to coordinate the activities of the various agencies. I would like to see a massive type of coordinated effort in dealing with services, in three areas: in program development, in the operation of the program, and in the services which are being rendered. I am sure there are other areas, as well?

Mr. Hayes: One of the other areas, obviously, would be education. Dr. Peters?

Dr. Peters: Education and training, broadly speaking. We see Vocational Rehabilitation as encompassing much more than an exploratory, vocational adaptability kind of program. Education, training, an eventual adjustment to the world of work; personal and social adjustment, -- all are part of the vocational rehabilitation program, and I agree with Miss Loiacono when she mentions the fact that she would like to see the program broadened. The philosophy has been broadened, but the program, in terms of eligibility requirement, leaves something to be desired.

Mr. Hayes: In the area of desire, one of the hopes of this program, the Project, is to come up with recommendations that could be presented to the Legislature to improve services. Mr Grella, do you have any suggestions in this area? What could the Planning Council, possibly, come up with?

Mr. Grella: Well, this might, perhaps, be premature because we haven't resolved our final recommendations, but one of the things which Miss Loiacono has mentioned and which has appeared constantly as a recommendation, from practically all of the regional committees, is more inter-agency cooperation. We have the feeling, very often, that the client of Vocational Rehabilitation may not be aware of all the services which are available to him, not only from Vocational Rehabilitation, but also from other State agencies; and, somehow or other, this kind of information must be communicated to the people who need it. Inter-agency cooperation is not something which can be simply achieved by discussions among people involved in the work. Somehow, it must be communicated both downward and upward, in the various State government and Federal agencies which are involved. The Statewide Planning Project will also have, hopefully, as one of its recommendations, some idea as to the future expansion of Vocational Rehabilitation services within the State. If the State of Connecticut had a static type of economy in which nothing much would change, this would present no real problem; but inasmuch as it is a very dynamic, aggressive economy, the environment in which the vocational rehabilitation must be placed, is constantly changing, so that we must try to find some way to take into account that change, in whatever plans we recommend.

Mr. Hayes: When we talk about the future, is there a possibility that future studies will also be needed?

Mr. Grella: Yes, we hope, obviously, that one of the results of this Statewide Planning Project will be an implementation of the recommendations which we make, and then a carrying forward of the initial plans and recommendations which are made, to further their acceptance at all levels within the State.

Mr. Hayes: I would like to thank each of you for coming in to talk about the problems of vocational rehabilitation, what the plans might be in the future, and what possibly can be done in this area....

"Your Community" has taken a look at a study launched earlier this year by the Governor's Planning Council for the Statewide Planning Project for Vocational Rehabilitation Services.

HARTFORD COURANT
Wednesday, May 15, 1968

POOR CHILDREARING SEEN LINK TO ALCOHOLISM

A former alcoholic Tuesday told the Governor's Planning Council for Rehabilitation Services that alcoholism and drug dependence "are too often the result of poor childrearing practices." James E. Carroll, rehabilitation counselor in the Alcoholism and Drug Dependence Unit at Connecticut Valley Hospital, said youngsters need to be provided with adequate character and personality development "that lead to the solutions of human problems without the need to resort to chemicals. "This is preventive medicine," he added.

Carroll was among many who cited the need for bigger, better and more effective rehabilitation programs during a day-long hearing at the State Capitol, presided over by Joseph W. Ress of West Hartford, council chairman. Gov. Dempsey opened the meeting and pointed to Connecticut's leadership in rehabilitation of the handicapped, commenting that the effort and money expended is a sound investment from the economics as well as the humanitarian point of view.

KEYNOTE SPEECH

Secretary of the State Ella T. Grasso, a leader in rehabilitation activities, keynoted the meeting. "Connecticut has led the nation in the rehabilitation movement since 1816 ... when the School for the Deaf was incorporated," Mrs. Grasso said. "From that day to this, in increasing measure, our aim has been to return dependent peoples to lives of productivity, dignity and financial independence," she said. Pointing out that voluntary organizations working with public agencies have built Connecticut's rehabilitation programs, she urged even greater coordination of effort "that we may achieve even greater progress."

Among those testifying at the meeting were Arthur E. Arsenault, vice president of Uniform Services, Inc., of Waterbury . Arsenault said"... there are needs for all types of handicapped personnel in our industry ... to fill rewarding jobs ... and to benefit industry." J. Bernard Gates, executive director of the Connecticut Prison Assn. and chairman of the Council of Correction, pointed out that the need for rehabilitation of ex-prisoners will become greater. He urged that the council provide for additional services in this area in its total program. The need for occupational training laboratories was described by Beatrice R. Fleeson, executive director of The Greater Hartford Assn. For Retarded Children, Inc. Mrs. Fleeson said, "approximately one-half of the students in Connecticut's large cities have one or more handicaps."

"Occupational training laboratories are urgently needed - to evaluate vocational skills - provide training and to help students adjust to job requirements," she said. Joseph P. Burns, District Director of Muscular Dystrophy Associations of America, Inc., pointed out that society's failure has been its obsession with the handicap rather than with the personality of the handicapped. "As one dystrophic put it: I am handicapped only when I admit to being so," Burns said. Sholom Bloom, executive secretary, Commission on Services For Elderly, recommended the establishment of closer liaison between Division of Vocational Rehabilitation and Commission on Services for Elderly Persons with both agencies providing designated staff for this responsibility.

HARTFORD COURANT
5/13/68

FUNDS SEEN WELL SPENT IN AID TO HANDICAPPED

State funds spent on rehabilitation of the handicapped is an "investment in human resources," according to Joseph W. Ress, chairman of the Governor's Planning Council of the Statewide Project for Vocational Rehabilitation Services. Money spent on rehabilitation can come back "one-thousand fold" in the handicapped person's contribution to the support of himself and his family and to the economy in general, he said. The Hartford attorney who heads up the Planning Council is volunteering his services, as are his colleages on the council. Ress has also served the Boys Clubs for many years and chaired the West Hartford Library Board for a lengthy period. But he regards his current stint with the rehabilitation group as "one of the most challenging tasks I've ever undertaken.

REHABILITATION PLAN

The Planning Council and the project staff, directed by Dr. Wesley C. Westman, a psychologist and research expert, are charged with developing a total rehabilitation plan for all of Connecticut's handicapped. The completed plan is to be implemented by 1975. Its recommendations will include programs for alcoholics, ex-prisoners, the educationally disadvantaged, the vocationally unskilled as well as for the mentally, physically, neurologically and emotionally handicapped. Ress is eager to involve "many, many citizens -- lay people who are interested in the handicapped -" in the study. Steps have been taken in this direction through the appointment of various regional committees who are advising the council and the staff, he said. The Planning Council will hold a public hearing Tuesday in the Judiciary Room of the State Capital at 9 a.m. Representatives of public and private agencies will be on hand for the all-day session, offering suggestions as to the needs in the various areas of the state. Secretary of the State Ella T. Grasso will keynote the meeting. It is expected that Gov. Dempsey will open the session and speak briefly.

424.

HARTFORD TIMES
5/15/68

REHAB SERVICES SEEN IN DEMAND

The Connecticut Planning Council for Vocational Rehabilitation has 1975 as a deadline for providing every handicapped person with full services to bring him back to gainful employment. At an all-day public hearing Tuesday, council members heard from representatives of public and private agencies dealing with physical and mental handicaps. Governor Dempsey estimated at least 60,000 Connecticut citizens could benefit from rehabilitation, and predicted the figure will be higher by 1975. Connecticut persons produce about 12,000 annually who need job training as well as other forms of rehabilitation, said Bernard Gates, of the Connecticut Prison Association. Gates also mentioned the impending problems of the effect of the Powell decision before the Supreme Court, which is expected to rule that chronic alcoholics cannot be convicted for drunkeness when no other crime is involved. Work is a major contribution to the happiness of older citizens, said Sholom Bloom, of the State Commission on Services for the Elderly. He declined to define "elderly" since some workers may be excluded from the labor market at 50. For purposes of retirement, Social Security and industries place a 65 year limit. Bloom called for information and referral offices for the elderly at the municapal level, as well as formation of a Senior Service Corp.

Ralph Adams, representing the alumni association of Oak Hill School for the Blind, said that often the training at his school is at odds with the State Board of Education for the Blind. For example, mobility training should be offered, he said.

He was also "shocked" to discover that some graduates have not been trained to write their own signatures. He also felt that some blind persons trained for a specific job were "stuck" in a job for a lifetime, even though they would prefer fomething else. Urban League spokesman, Sam Wilson said that young Negroes are fearful of the personnel interview process and are conditioned to accept failure. They find tests frightening. They expect to fail, and so, often do.